CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/08/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	COMPL	
		155757	A. BUII B. WIN			02/25/2	011
			P. WIIN		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF P	PROVIDER OR SUPPLIER				ROSEGATE DR		
	TE VILLAGE LLC				NAPOLIS, IN46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
PREFIX TAG F0000	This visit was for State Licensure Provider number: 200 Survey team: Teresa Buske RN Mary Weyls RN Laura Brashear RC Census bed type: SNF: 38 SNF/NF: 107 Total: 145 Census payor typ Medicare: 41 Medicaid: 84 Other: 20 Total: 145 Sample: 24 Supplemental sar These deficiencies findings cited in a 16.2.	r a Recertification and Survey. bruary 21-25, 2011 011149 : 155757 0829340 I/TC RN pe: mple: 5 es also reflect state accordance with 410 IAC	F00		CRACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY) The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation regulation. This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credial Allegation and requests a Possurvey Review on or after Ma 27, 2011.	of ot s : n of ble	COMPLETION DATE
	Quality review 3/	/02/11 by Suzanne					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EQ7B11

Facility ID:

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN46237					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION JLD BE ROPRIATE	(X5) COMPLETION DATE		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155757			A. BUILDING COMPLI			(X3) DATE SURVEY COMPLETED 02/25/2011
	PROVIDER OR SUPPLIER		B. WIN	7510 R	ADDRESS, CITY, STATE, ZIP CODE ROSEGATE DR NAPOLIS, IN46237	
	SEGATE VILLAGE LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Based on observation,		F02	7510 R INDIAN ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • A 30 day restraint review has been completed for resident #52. How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take • All residents have been identified that are currently confort the use of a restraint. • All residents identified have had a day restraint review form completed. What measures will be put in place or what systemic	DATE 1 03/27/2011 n r al n? ded a 30
	was identified release alarm wheelchair. the resident I on 2/23/11 at the supper mass observed room, seated with the seat	ed as utilizing a self ned seat belt in the RN #19 indicated had no recent falls. at 4:40 p.m., during neal, Resident #52 d in the dining in a wheelchair belt on. A family sobserved seated			changes you will make to ensure that the deficient practice does not recur? The ongoing use of a physical restraint will be reviewed even days by the interdisciplinary the and the monthly restraint revies form will be completed. All residents that are currently confor the use of restraints will be scheduled for IDT review even 30 days after initiation of restraints per policy. In-services will be held to train the interdisciplinateam on the use and important of the 30 day restraint review. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality	y 30 am, ew ded y aint ry ce

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EQ7B11 Facility ID:

011149

If continuation sheet

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED	
155757	B. WING		02/25/2011	
NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE LLC	STREET AD 7510 ROS	DDRESS, CITY, STATE, ZIP CODE SEGATE DR POLIS, IN46237		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
On 2/24/11 at 12:05 p.m., whi seated in the wheelchair by the nurses' station, Resident #52 was able to release the seat be upon command. Resident #52's clinical record was reviewed on 2/25/11 at 11:25 a.m. The resident's diagnoses included, but was not limited to, delirium and dementia. A physician's order was noted dated 2/17/10 for self release belt at all times in wheelchair. A quarterly MDS [Minimum Data Set] assessment, completed on 1/12/11 coded the resident with no falls, and utilized a trunk restraint. A plan of care with original date of 10/25/10, addressed the	t	assurance program will be p into place? · A CQI audit tool be utilized by DNS/designee to monitor compliance of the 30 or restraint review form weekly X weeks, monthly X 2 months an quarterly thereafter. · Results these evaluation processes wibe presented to the CQI Committee monthly to review compliance and follow-up. Identified noncompliance may result in staff re-education and disciplinary action.	will o day 4 nd of ill	

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPLE	
		155757	B. WIN			02/25/20	11
NAME OF F	PROVIDER OR SUPPLIEF	₹		1	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR		
	ATE VILLAGE LLC			1	IAPOLIS, IN46237		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
TAG	· ·	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	problem of '	'Needs SELF					
	RELEASIN	G ALARMING					
	BELT restra	ints to prevent					
	injury due to	POOR SAFETY					
		SS, IMPAIRED					
	COGNITIO	N." Interventions					
	with estimat	ted date of 4/13/11					
	included, but were not limited						
	to, Restraint	when up in					
	wheelchair,	check every hour,					
	release ever	y 2 hours, evaluate					
	at least ever	y three months for					
	less restricti	ve measures, and					
	IDT [Interdi	sciplinary team] to					
	review for le	east restrictive					
	device per p	olicy.					
		-					
	An Interdisc	eiplinary Team					
	Progress No	te, dated 10/19/10					
		: IDT met to					
		ents [sic] restraints.					
		it] continues to					
	utilize self r	-					
] belt @ [at] all					
	times when	up in wc d/t [due					
					<u> </u>		

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Event ID:

EQ7B11 Facility ID:

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155757	B. WIN			02/25/2	011
	PROVIDER OR SUPPLIER		•	7510 R	DDRESS, CITY, STATE, ZIP CODE OSEGATE DR APOLIS, IN46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	to] poor safe	ety awareness. Res					
	has hx of falls and DX						
		of Dementia. Res.					
		belt but not always					
		d. No s/s [signs,					
	• • •	of distress related to					
		seat belt. Res.					
	currently on						
	programIDT feels @ this						
		release we seat					
	belt is indica						
		er abilities to stand					
	and transfer	seii					
	The facility's	s policy titled					
		straints" dated					
	3/10, provid	ed by the DON on					
	2/25/11 at 3:	45 p.m. included,					
	but was not	limited to:					
	"Restraint	use will be					
	considered c	only after less					
	restrictive m	easures have					
	failed, and the	ne interdisciplinary					
	team determ	ines that they are					
	needed to tre	eat resident (s)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	(X3) DATE COMPI 02/25/2	LETED
	PROVIDER OR SUPPLIER		STREET A 7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR APOLIS, IN46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	medical sym	ptoms11. The				
	ongoing use	of a physical				
	restraint will	l be reviewed every				
	30 days by t	he interdisciplinary				
	team, and th	e monthly restraint				
	review form	will be completed.				
	12. The "mo	onthly restraint				
	review" forn	n will indicate any				
	reduction attempts and					
	rationale for	continued use."				
	2/25/11 at 3: indicated the documentation to reduce the last six months ensure that a	on of any attempts e restraint in the ths, and could not				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPLETED	
		155757	B. WING			02/25/2011	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DOOFOA	TE VIII AOE II O		7510 ROSEGATE DR				
	ATE VILLAGE LLC				NAPOLIS, IN46237		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE	
F0286		erview and record	F02		What corrective action(s) wil		
SS=E	review, the facility failed to				be accomplished for those residents found to have beer	ı	
	maintain cor	mplete 3.0			affected by the deficient practice? · Completed 3.0		
	Minimum D	ata Set			Minimum Data Set Assessmer	nts	
	Assessments	s of 17 of 20			were immediately printed and placed on Resident #1's clinicated	al	
	residents rev	riewed in an sample			record and made accessible to professional staff members.	o all	
	of 24, requir	ed to have a			· Completed 3.0 Minimum Dat	a	
	Minimum D	ata Set			Set Assessments were immediately printed and place	d	
	Assessment, in that completed				on Resident #4's clinical recor	d	
	3.0 Minimur	•			and made accessible to all professional staff members.		
	assessments				· Completed 3.0 Minimum Dat Set Assessments were	a	
		on the residents'			immediately printed and place		
		rds, or accessible			on Resident #15's clinical reco	ord	
					professional staff members.		
	to all profess				· Completed 3.0 Minimum Dat Set Assessments were	a	
	_	Residents #1, #4,			immediately printed and place	d	
	#15, #16, #1	7, #119, #86, #127,			on Resident #16's clinical reco	ord	
	#133, #112,	#97, # 33, # 87,			and made accessible to all professional staff members.		
	#49, #36, #4	5. #391			· Completed 3.0 Minimum Dat	a	
	,	·,,]			Set Assessments were immediately printed and place	d	
	Eindings inc	ludo:			on Resident #17's clinical reco		
	Findings inc	lude.			and made accessible to all		
					professional staff members. Completed 3.0 Minimum Dat	a	
	1. On 2/21/1	11 at 2:30 p.m.,			Set Assessments were		
	Resident #1'	s clinical record			immediately printed and place on Resident #119's clinical rec		
	was reviewed. A 3.0 Minimum				and made accessible to all		
	Data Set Ass	sessment,			professional staff members. · Completed 3.0 Minimum Dat	a	

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T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155757	A. BUII B. WIN			02/25/2011
PROVIDER OR SUPPLIER			7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR IAPOLIS, IN46237	
Summary, an [Assessment were on the control of the	dentification J. Section V [Care ment (CAA) and Section Z Administration] clinical record. Hearing, Speech, Section C atterns], Section D tion E [Behavior], references for Routine and		7510 R	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) Set Assessments were immediately printed and place on Resident #86's clinical recommediately printed and place on Resident #127's clinical recommediately printed and place on Resident #133's clinical recommediately printed and place on Resident #133's clinical recommediately printed and place on Resident #112's clinical recommediately printed and place on Resident #97's clinical recommediately printed and place on Resident #97's clinical recommediately printed and place on Resident #33's clinical recommediately printed and place on Resident #	d ord a d cord a d co
[Health Cond [Swallowing	ditions], Section K			Set Assessments were immediately printed and place on Resident #87's clinical recoand made accessible to all professional staff members.	ı
				!	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S COMPL			
		155757	A. BUII B. WIN	LDING IG			02/25/2011	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	R		1	OSEGATE DR			
	ATE VILLAGE LLC				IAPOLIS, IN46237			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	· `	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE	
	Status] Secti				· Completed 3.0 Minimum Dat	а		
	Conditions	Section N		Set Assessments were immediately printed and placed		d		
	l	Conditions], Section N			on Resident #49's clinical reco			
		s], Section O			and made accessible to all			
	[Special Tre	atments,			professional staff members. · Completed 3.0 Minimum Dat	a		
	Procedures.	and Programs,]			Set Assessments were	<u> </u>		
	Section P [Restraints], Section				immediately printed and place			
	-	- '			on Resident #36's clinical reco	ord		
	Q [Participation in Assessment and Goal Setting], were not on the clinical record.				professional staff members.			
					· Completed 3.0 Minimum Dat	а		
					Set Assessments were	d		
					immediately printed and place on Resident #45's clinical reco			
					and made accessible to all	,, ,		
	The Admini	strator was			professional staff members.			
	interviewed	on 2/21/11 at 3:00			· Completed 3.0 Minimum Dat Set Assessments were	a		
	p.m. The A	dministrator			immediately printed and place	d		
	l [*]				on Resident #39's clinical reco	ord		
	indicated the	•			and made accessible to all professional staff members. F	low		
	assessment v	was not maintained			will you identify other reside			
	on the chart,	or accessible to all			having the potential to be			
	professional				affected by the same deficier	nt		
	Professionar	DWII.			practice and what corrective action will be taken?			
					· Completed 3.0 Minimum Dat	a l		
	2. On 2/24/1	1 at 3:35 p.m.,			Set Assessments were			
	Resident #4'	s clinical record			immediately printed and place			
	Was reviewe	ed. A 3.0 Minimum			on all residents' clinical record and made accessible to all	5		
					professional staff members.			
	Data Set Ass	· ·			What measures will be put in	ito		
	completed o	n 2/14/11 was on			place or what systemic changes you will make to			
	the record.				ensure that the deficient			
					practice does not recur?			
					· Facility has eliminated the us	e		

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/25/2011	
NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL			7510 RG INDIAN	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR APOLIS, IN46237 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
	The Admini interviewed a.m. The Adindicated the assessments maintained of the day before assessments placed on the by the facility. The Admini Section A [Information Area Assess Summary, a [Assessment had been plated on the day before assessments placed on the by the facility. The Admini Section A [Information Area Assess Summary, a [Assessment had been plated by the facility of	strator was on 2/22/11 at 9:45 dministrator e completed had not been on the chart prior to ore when all were printed and e clinical records ty choice. strator indicated dentification], Section V [Care ment (CAA) nd Section Z t Administration] aced on the clinical ections B [Hearing, Vision,] Section C Patterns], Section D etion E [Behavior], references for Routine and		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (REACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) of the Electronic Storage of M (Minimum Data Set) policy. Facility practice has been revised so that completed 3.0 Minimum Data Set Assessmen will be printed and placed on a residents' clinical records and made accessible to all professional staff members. MDS staff and other professional staff will be educa on the revised facility practice. How the corrective action (s)will be monitored to ensur the deficient practice will not recur, i.e., what quality assurance program will be p into place? A CQI tool will be utilized by MDS Coordinator/designee to monit compliance with printing and making accessible completed MinimumData Set Assessmen weekly x 4 weeks, monthly x2 months and quarterly thereafte Results of the audit will be presented to the CQI Committ monthly to ensure compliance and follow-up. Identified noncompliance may result in s re-education and/or disciplinal action.	DS Ints Ints Interest Interes	COMPLETION DATE

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPL		
		155757	A. BUI B. WIN			02/25/2	011
NAME OF I	PROVIDER OR SUPPLIER	<u></u>	•		DDRESS, CITY, STATE, ZIP CODE		
ROSEGA	ATE VILLAGE LLC			1	DSEGATE DR APOLIS, IN46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	COMPLETION DATE
	[Functional	Status], Section H					
	[Bladder and Bowel], Section I						
	[Active Diag	gnoses], Section J					
	[Health Con	ditions], Section K					
	[Swallowing	g/Nutritional					
	Status], Sect	tion L [Oral/Dental					
	Status] Secti	ion M [Skin					
	Conditions], Section N						
	[Medications], Section O						
	[Special Tre	atments,					
	Procedures,	and Programs,]					
	Section P [R	estraints], Section					
	Q [Participa	tion in Assessment					
	and Goal Se	tting], had not until					
	after discuss	ion with surveyors.					
	з. On 2/24/1	1 at 4:30 p.m.,					
	Resident #1:	5's clinical record					
	was reviewe	d. A 3.0 Minimum					
	Data Set Ass	sessment,					
	completed o	n 2/16/11 was on					
	the record.						
	The Admini						
	ınterviewed	on 2/22/11 at 9:45					

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE COMPL	
		155757	A. BUILI B. WING			02/25/2	011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
ROSEGA	ATE VILLAGE LLC				APOLIS, IN46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	a.m. The Ac	lministrator					
	indicated the	e completed					
	assessments	had not been					
	maintained o	on the chart prior to					
	the day befo	re when all					
	assessments	were printed and					
	placed on th	e clinical records					
	by the facility choice.						
	The Administrator indicated						
	Section A [Id	dentification					
	Information]	, Section V [Care					
	Area Assess	ment (CAA)					
	Summary, a	nd Section Z					
	[Assessment	Administration]					
	had been pla	aced on the clinical					
	record but S	ections B [Hearing,					
	Speech, and	Vision,] Section C					
	[Cognitive P	atterns], Section D					
	[Mood], Sec	tion E [Behavior],					
	Section F [P	references for					
	Customary I	Routine and					
	Activities], S	Section G					
	[Functional	Status], Section H					
	[Bladder and	d Bowel], Section I					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155757		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE (COMPL 02/25/2	ETED
NAME OF F	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
ROSEGA	ATE VILLAGE LLC			1	DSEGATE DR APOLIS, IN46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	[Active Diag	gnoses], Section J					
	[Health Conditions], Section K						
	[Swallowing	y/Nutritional					
	Status], Sect	ion L [Oral/Dental					
	Status] Section M [Skin						
	Conditions],	Section N					
	[Medication:	s], Section O					
	[Special Trea	atments,					
	Procedures,	and Programs,]					
	Section P [R	estraints], Section					
	Q [Participat	tion in Assessment					
	and Goal Se	tting], had not until					
		ion with surveyors.					
	4. On 2/25/1 Resident #16 was reviewe Data Set Ass	1 at 10:50 a.m., 6's clinical record d. A 3.0 Minimum					
	The Administrates interviewed a.m. The Admindicated the	on 2/22/11 at 9:45 lministrator					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757			LDING	INSTRUCTION	(X3) DATE S COMPLI 02/25/20	ETED
DROLUDER OR GURRI IER		B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
				APOLIS, IN46237		
			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	AIE.	DATE
assessments	had not been					
maintained on the chart prior to						
the day before when all						
assessments were printed and						
placed on the	e clinical records					
by the facilit	cy choice.					
The Administrator indicated						
Section A [Identification						
Area Assessi	ment (CAA)					
Summary, aı	nd Section Z					
_						
-	-					
1						
	- -					
	· -					
-	- '					
_						
-	- '					
-	-					
-						
	umonsj, seemon K					
	revider or supplier summary summary or assessments maintained of the day before assessments placed on the by the facility. The Administic Section A [Id Information] Area Assessing Summary, at [Assessment had been plated of the day before assessments placed on the by the facility. The Administic Section A [Id Information] Area Assessing Summary, at [Assessment had been plated by the facility of t	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) assessments had not been maintained on the chart prior to the day before when all assessments were printed and placed on the clinical records by the facility choice. The Administrator indicated	IDENTIFICATION NUMBER: 155757 A. BUIL AS BUIL AS BUIL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) assessments had not been maintained on the chart prior to the day before when all assessments were printed and placed on the clinical records by the facility choice. The Administrator indicated Section A [Identification Information], Section V [Care Area Assessment (CAA) Summary, and Section Z [Assessment Administration] had been placed on the clinical record but Sections B [Hearing, Speech, and Vision,] Section C [Cognitive Patterns], Section D [Mood], Section E [Behavior], Section F [Preferences for Customary Routine and Activities], Section G [Functional Status], Section I [Active Diagnoses], Section J	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) assessments had not been maintained on the chart prior to the day before when all assessments were printed and placed on the clinical records by the facility choice. The Administrator indicated Section A [Identification Information], Section V [Care Area Assessment (CAA) Summary, and Section Z [Assessment Administration] had been placed on the clinical record but Sections B [Hearing, Speech, and Vision,] Section C [Cognitive Patterns], Section D [Mood], Section E [Behavior], Section F [Preferences for Customary Routine and Activities], Section G [Functional Status], Section I [Active Diagnoses], Section J	DENTIFICATION NUMBER: 155757 A. BUILLDING	DENTIFICATION NUMBER: 155757 A BUILDING R WING R W

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPL	ETED	
		155757	B. WIN			02/25/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR		
	ATE VILLAGE LLC			1	APOLIS, IN46237		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	[Swallowing	y/Nutritional					
	Status], Sect	ion L [Oral/Dental					
	Status] Secti	on M [Skin					
	Conditions],	Section N					
	[Medication:	s], Section O					
	[Special Trea	atments,					
	Procedures,	and Programs,]					
	Section P [Restraints], Section						
	Q [Participat	tion in Assessment					
	and Goal Set	tting], had not until					
	after discuss	ion with surveyors.					
	5. On 2/25/1	1 at 11:50 p.m.,					
	Resident #17	7's clinical record					
	was reviewe	d. A 3.0 Minimum					
	Data Set Ass	sessment,					
	completed of	n 2/10/11 was on					
	the record.						
	The Adminis	strator was					
	interviewed	on 2/22/11 at 9:45					
	a.m. The Ac						
	indicated the						
		had not been					
		on the chart prior to					
		m die viidit piioi to					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE : COMPL	
		155757	A. BUILDIN B. WING	G		02/25/2	
	PROVIDER OR SUPPLIER		ST 75	510 RC	DDRESS, CITY, STATE, ZIP CODE DSEGATE DR APOLIS, IN46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	IC PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	the day befo	re when all		ĺ			
	assessments were printed and						
	placed on the						
	by the facilit						
	Section A [Id Information] Area Assess Summary, and [Assessment had been plan record but Son Speech, and [Cognitive Polymond], Section F [Polymond], Secti	I, Section V [Care ment (CAA) and Section Z and Administration] aced on the clinical ections B [Hearing, Vision,] Section C atterns], Section D tion E [Behavior], references for Routine and Section G Status], Section H Bowel], Section I gnoses], Section J ditions], Section K					
	[Swallowing Status]. Sect	g/Nutritional ion L [Oral/Dental					

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		155757	A. BUILDING B. WING		02/25/2011
NAME OF F	PROVIDER OR SUPPLIER	<u></u>		ADDRESS, CITY, STATE, ZIP CODE	
ROSEGA	ATE VILLAGE LLC			OSEGATE DR IAPOLIS, IN46237	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	
	Status] Secti	ion M [Skin			
	Conditions],	Section N			
	[Medication	s], Section O			
	[Special Tre	atments,			
	ŕ	and Programs,]			
	=	estraints], Section			
		tion in Assessment			
		tting], had not until			
	after discuss	ion with surveyors.			

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED
		155757	B. WIN			02/25/2011
NAME OF F	AD OUTDED ON GUIDNI TED				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			7510 R	OSEGATE DR	
	ATE VILLAGE LLC				IAPOLIS, IN46237	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)			CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
F0286		s clinical record was	E02		What corrective action(s) will	
			F0286 What corrective action(s) will be accomplished for those			03/2//2011
SS=E	reviewed on 2/21/11 at 1:45 p.m.				residents found to have been	1
	An admission date of 10/26/10 was noted.				affected by the deficient	
					practice? · Completed 3.0	,
	G .: A FT	1			Minimum Data Set Assessmer were immediately printed and	nts
	Section A [Id	aentification			placed on Resident #1's clinica	al
	Information]	, and Section Z			record and made accessible to	
	_	Administration]			professional staff members. Completed 3.0 Minimum Data	a
	were on the	clinical record.			Set Assessments were	
		cilifical record.			immediately printed and place	
					on Resident #4's clinical record and made accessible to all	d
	Sections B [Hearing, Speech,				professional staff members.	
	and Vision,]	Section C			· Completed 3.0 Minimum Data	a
					Set Assessments were	
		Patterns], Section D			immediately printed and place on Resident #15's clinical reco	
	[Mood], Sec	tion E [Behavior],			and made accessible to all	Jiu I
	Section F [P	references for			professional staff members.	
	Customary F				Completed 3.0 Minimum Data Set Assessments were	a
	_				immediately printed and place	d
	Activities], S	Section G			on Resident #16's clinical reco	
	[Functional :	Status], Section H			and made accessible to all	
	-	l Bowel], Section I			professional staff members. Completed 3.0 Minimum Data	<u> </u>
	_	_			Set Assessments were	٩
	- ·	gnoses], Section J			immediately printed and place	d
	[Health Con-	ditions], Section K			on Resident #17's clinical reco	ord
	Swallowing	/Nutritional			and made accessible to all professional staff members.	
	-				Completed 3.0 Minimum Data	a
		ion L [Oral/Dental			Set Assessments were	
	Status] Secti	on M [Skin			immediately printed and place	
	Conditions],	Section N			on Resident #119's clinical rec	cora
					professional staff members.	
	Liviedications	s], Section O			· Completed 3.0 Minimum Data	a

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EQ7B11 Facility ID:

011149

If continuation sheet

Page 19 of 80

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155757	A. BUILDING			02/25/2011
		100707	B. WIN			02/20/2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
ROSEGA	ATE VILLAGE LLC			1	OSEGATE DR NAPOLIS, IN46237	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	1	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	[Special Trea	atments,			Set Assessments were immediately printed and place	ed.
	Procedures, and Programs,]			on Resident #86's clinical record		
	Section P [R	estraints], Section			and made accessible to all professional staff members.	
	Q [Participat	tion in Assessment			· Completed 3.0 Minimum Date Set Assessments were	ta
	and Goal Set	tting], were not on			immediately printed and place	ed
	the clinical r	-			on Resident #127's clinical red	cord
					and made accessible to all professional staff members.	
	The Adminis	strator was			· Completed 3.0 Minimum Dat	ta
					Set Assessments were immediately printed and place	,d
	interviewed on 2/21/11 at 3:00				on Resident #133's clinical red	
	p.m. The Ac	dministrator			and made accessible to all	
	indicated the	e completed			professional staff members. Completed 3.0 Minimum Date	ra
	assessment v	was not maintained			Set Assessments were	
	on the chart.	or accessible to all			immediately printed and place on Resident #112's clinical red	
	professional				and made accessible to all	
	proressionar	Staff.			professional staff members.	to
	Duine intensity of	M. Dimerton CM			· Completed 3.0 Minimum Dat Set Assessments were	.a
		the Director of Nursing on the DON indicated the			immediately printed and place	ed .
		omputerized. The DON			on Resident #97's clinical reco	ord
		raff with access to the			and made accessible to all professional staff members.	
		e staff that entered the			Completed 3.0 Minimum Date	ta
		computer. The DON also sessments, after October 2010			Set Assessments were	
		e resident's clinical record and			immediately printed and place	
	placed into overflow				on Resident #33's clinical reco	ord
					professional staff members.	
	7. Resident #112's clinical record was reviewed				Completed 3.0 Minimum Dat	a
	on 2/22/11 at 2:55 p	.III.			Set Assessments were	.d
	A significant change assessment was noted, dated 5/31/10, and a quarterly assessment was noted,				immediately printed and place on Resident #87's clinical reco	•
					and made accessible to all	
	dated 11/24/10.				professional staff members.	

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155757	A. BUILDING		02/25/2011	
		100707	B. WING	ADDRESS, CITY, STATE, ZIP CODE	02/20/2011	
NAME OF I	PROVIDER OR SUPPLIER			ROSEGATE DR		
	ATE VILLAGE LLC			NAPOLIS, IN46237		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
	.	CY MUST BE PERCEDED BY FULL I SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI		
TAG	The Administrative wed a.m. The Administration of the day before assessments placed on the by the facility. The Administration A [Information] Area Assessments Summary, at [Assessment had been plated on the byte facility. The Administration of the Administration o	on 2/22/11 at 9:45 dministrator e completed had not been on the chart prior to re when all were printed and e clinical records ty choice. strator indicated dentification J. Section V [Care ment (CAA) and Section Z the Administration aced on the clinical ections B [Hearing, Vision,] Section C catterns], Section D tion E [Behavior], references for	TAG	Completed 3.0 Minimum Da Set Assessments were immediately printed and place on Resident #49's clinical recand made accessible to all professional staff members. Completed 3.0 Minimum Da Set Assessments were immediately printed and place on Resident #36's clinical recand made accessible to all professional staff members. Completed 3.0 Minimum Da Set Assessments were immediately printed and place on Resident #45's clinical recand made accessible to all professional staff members. Completed 3.0 Minimum Da Set Assessments were immediately printed and place on Resident #39's clinical recand made accessible to all professional staff members. Will you identify other resident will you identify other resident will you identify other resident practice and what corrective action will be taken? Completed 3.0 Minimum Da Set Assessments were immediately printed and place on all residents' clinical reconding the potential to be affected by the same deficite practice and what corrective action will be taken? Completed 3.0 Minimum Da Set Assessments were immediately printed and place on all residents' clinical reconding made accessible to all professional staff members. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? Facility has eliminated the united that the deficient practice does not recur?	ed cord data ed co	

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE S COMPL	
		155757	A. BUILDIN B. WING	NG		02/25/2	
ROSEG/	PROVIDER OR SUPPLIER		75 IN	510 RC NDIANA	DDRESS, CITY, STATE, ZIP CODE DSEGATE DR APOLIS, IN46237		9/5
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	[Bladder and [Active Diag [Health Con [Swallowing Status], Sect Status] Secti Conditions], [Medications [Special Tresponderes, Section P [R Q [Participat and Goal Seafter discuss 8. Resident record was r 2/23/11 at 1: A 2.0 annual noted, dated	Status], Section H d Bowel], Section I gnoses], Section J ditions], Section K g/Nutritional ion L [Oral/Dental ion M [Skin Section N s], Section O atments, and Programs,] estraints], Section tion in Assessment tting], had not until ion with surveyors. #133's clinical eviewed on 15 p.m. d assessment was 5/13/11 and a 0 assessment was			of the Electronic Storage of MI (Minimum Data Set) policy. Facility practice has been revised so that completed 3.0 Minimum Data Set Assessmer will be printed and placed on a residents' clinical records and made accessible to all professional staff members. MDS staff and other professional staff will be educa on the revised facility practice. How the corrective action (s)will be monitored to ensurthe deficient practice will not recur, i.e., what quality assurance program will be printo place? A CQI tool will be utilized by MDS Coordinator/designee to monit compliance with printing and making accessible completed MinimumData Set Assessment weekly x 4 weeks, monthly x2 months and quarterly thereafted. Results of the audit will be presented to the CQI Committed monthly to ensure compliance and follow-up. Identified noncompliance may result in stre-education and/or disciplinar action.	e e e e e e e e e e e e e e e e e e e	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2011
	PROVIDER OR SUPPLIER		STREET A 7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR IAPOLIS, IN46237	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	a.m. The Adindicated the assessments maintained of the day before assessments placed on the by the facility. The Administ Section A [Id Information] Area Assessing Summary, and [Assessment had been planted by the facility of the facility of the Administ Section A [Id Information] area Assessing Summary, and [Assessment had been planted by the facility of the facil	on 2/22/11 at 9:45 Iministrator completed had not been on the chart prior to re when all were printed and ce clinical records by choice. Strator indicated dentification [Section V [Care ment (CAA) and Section Z cadministration] ced on the clinical ections B [Hearing, Vision,] Section C catterns], Section D tion E [Behavior], references for			

PRINTED: 04/08/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION	COMPL	
		155757	A. BUI B. WIN	LDING IG		02/25/2	011
NAME OF I	PROVIDER OR SUPPLIER	<u></u>	•		DDRESS, CITY, STATE, ZIP CODE	•	
ROSEGA	ATE VILLAGE LLC			1	OSEGATE DR APOLIS, IN46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	Activities],	Section G					
	[Functional	Status], Section H					
	[Bladder and						
	[Active Diag	gnoses], Section J					
	-	ditions], Section K					
	[Swallowing	g/Nutritional					
	Status], Sect	tion L [Oral/Dental					
	Status] Section M [Skin						
	Conditions], Section N						
	[Medication	s], Section O					
	[Special Tre	atments,					
	Procedures,	and Programs,]					
	Section P [R	estraints], Section					
	Q [Participa	tion in Assessment					
	and Goal Se	tting], had not until					
	after discuss	ion with surveyors.					
	9. Resident	#127's clinical					
	record was r	eviewed on					
	2/24/11 at 11	1:25 a.m.					
	A significan	t change					
	assessment v	was noted, dated					
	12/20/10.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757			(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2011	
	PROVIDER OR SUPPLIER	!!	7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR IAPOLIS, IN46237	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION
	The Adminis				
		on 2/22/11 at 9:45			
	a.m. The Ac				
	indicated the	-			
		had not been			
		on the chart prior to			
	the day befo				
		were printed and			
	placed on the clinical records				
	by the facilit	ty choice.			
		strator indicated			
	_	dentification			
	l -], Section V [Care			
		ment (CAA)			
		nd Section Z			
	<u> </u>	t Administration]			
	_	aced on the clinical			
		ections B [Hearing,			
		Vision,] Section C			
	[Cognitive P	Patterns], Section D			
		tion E [Behavior],			
	Section F [P	references for			
	Customary I	Routine and			
	Activities], S	Section G			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757			(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 02/25/2011	
	PROVIDER OR SUPPLIER		7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR IAPOLIS, IN46237	1		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	[Bladder and [Active Diag [Health Con [Swallowing Status], Section P [Rection P]	ion L [Oral/Dental on M [Skin Section N s], Section O					
	and Goal Seafter discuss 10. Resident record was record was record was record and an annual and 6/27/10 and	tting], had not until ion with surveyors. t #86's clinical eviewed on 40 p.m. ssessment, dated a quarterly lated December					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757			(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2011	
	PROVIDER OR SUPPLIER	!!	7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR IAPOLIS, IN46237	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION
	The Adminis				
		on 2/22/11 at 9:45			
	a.m. The Ac				
	indicated the	-			
		had not been			
		on the chart prior to			
	the day befo				
		were printed and			
	placed on the clinical records				
	by the facilit	ty choice.			
		strator indicated			
	_	dentification			
	l -], Section V [Care			
		ment (CAA)			
		nd Section Z			
	<u> </u>	t Administration]			
	_	aced on the clinical			
		ections B [Hearing,			
		Vision,] Section C			
	[Cognitive P	Patterns], Section D			
		tion E [Behavior],			
	Section F [P	references for			
	Customary I	Routine and			
	Activities], S	Section G			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2011	
	PROVIDER OR SUPPLIER	: :	STREET A 7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR APOLIS, IN46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	[Functional of Eladder and Eladder and Eladder and Eladder and Eladder and Eladder Ela	Status], Section H d Bowel], Section I gnoses], Section J ditions], Section K g/Nutritional ion L [Oral/Dental on M [Skin Section N s], Section O				
	after discuss 11. Residen record was r 2/24/11 at 4: A significant assessment,	34 p.m.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757			(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2011	
	PROVIDER OR SUPPLIER	!!	7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR IAPOLIS, IN46237	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION
	The Adminis				
		on 2/22/11 at 9:45			
	a.m. The Ac				
	indicated the	-			
		had not been			
		on the chart prior to			
	the day befo				
		were printed and			
	placed on the clinical records				
	by the facilit	ty choice.			
		strator indicated			
	_	dentification			
	l -], Section V [Care			
		ment (CAA)			
		nd Section Z			
	<u> </u>	t Administration]			
	_	aced on the clinical			
		ections B [Hearing,			
		Vision,] Section C			
	[Cognitive P	Patterns], Section D			
		tion E [Behavior],			
	Section F [P	references for			
	Customary I	Routine and			
	Activities], S	Section G			

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		155757	A. BUILDING B. WING		02/25/2011
NAME OF F	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	
ROSEGA	ATE VILLAGE LLC		I	OSEGATE DR IAPOLIS, IN46237	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION DATE
IAU		Status], Section H	IAU		DATE
	-	Bowel], Section I			
	-	gnoses], Section J			
	-	ditions], Section K			
	[Swallowing	- ·			
		ion L [Oral/Dental			
	Status] Secti	_			
	Conditions],	-			
		s], Section O			
	Special Trea	=			
	- *	and Programs,]			
	•	estraints], Section			
	_	tion in Assessment			
	and Goal Se	tting], had not until			
		ion with surveyors.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757		A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/25/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN46237				
ROSEGATE VILLAGE LLC (X4) ID SUMMARY STATEMENT OF DEFICIT (EACH DEFICIENCY MUST BE PERCEDEN REGULATORY OR LSC IDENTIFYING INF F0286 12. On 2/21/11 at 1:45 p Resident #87's clinical rewas reviewed. A 3.0 Min Data Set Assessment, completed on 12/15/10, which is not on the resident's clinical record, or accessible to professional staff. Section A [Identification Information], Section V [Identification]		cy must be perceded by full LSC identifying information) /11 at 1:45 p.m., /'s clinical record d. A 3.0 Minimum sessment, n 12/15/10, was sident's clinical cessible to staff. dentification	F02	INDIAN ID PREFIX TAG		n nts al o all a d	(X5) COMPLETION DATE 03/27/2011
	[Assessment were on the Sections B [and Vision,] [Cognitive P [Mood], Sec Section F [P Customary F Activities], S [Functional Section I	Administration] clinical record. Hearing, Speech, Section C atterns], Section D tion E [Behavior], references for Routine and			immediately printed and place on Resident #15's clinical recording and made accessible to all professional staff members. Completed 3.0 Minimum Data Set Assessments were immediately printed and place on Resident #16's clinical recording and made accessible to all professional staff members. Completed 3.0 Minimum Data Set Assessments were immediately printed and place on Resident #17's clinical recording and made accessible to all professional staff members. Completed 3.0 Minimum Data Set Assessments were immediately printed and place on Resident #119's clinical recording and made accessible to all professional staff members. Completed 3.0 Minimum Data Set Assessments were immediately printed and place on Resident #119's clinical recording and made accessible to all professional staff members. Completed 3.0 Minimum Data Set Assessments were and made accessible to all professional staff members.	ord a d ord a d ord a d cord	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		155757	B. WIN			02/25/2011
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER			7510 R	OSEGATE DR	
	ATE VILLAGE LLC				IAPOLIS, IN46237	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	· `	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
IAU		gnoses], Section J	-	IAG	Set Assessments were	DATE
	l -	ditions], Section K			immediately printed and place on Resident #86's clinical reco	
	=	-			and made accessible to all	
	[Swallowing	g/Nutritional			professional staff members.	
	Status], Sect	ion L [Oral/Dental			· Completed 3.0 Minimum Dat Set Assessments were	a
	Status] Secti	on M [Skin			immediately printed and place	
	Conditions],	Section N			on Resident #127's clinical red and made accessible to all	cord
	Medication	s], Section O			professional staff members.	
	[Special Treatments, Procedures, and Programs,]				· Completed 3.0 Minimum Dat Set Assessments were	a
					immediately printed and place	d
	1	·			on Resident #133's clinical red	cord
	Section P [R	estraints], Section			and made accessible to all professional staff members.	
	Q [Participa	tion in Assessment			· Completed 3.0 Minimum Dat	a
		tting], were not on			Set Assessments were	.
	the clinical r	-			immediately printed and place on Resident #112's clinical red	
		ccord.			and made accessible to all	
					professional staff members.	
	The Adminis	strator was			· Completed 3.0 Minimum Dat Set Assessments were	a
	interviewed	on 2/21/11 at 3:00			immediately printed and place	d
	p.m. The Ac				on Resident #97's clinical reco	ord
	l ⁻				and made accessible to all professional staff members.	
	indicated the	e completed			· Completed 3.0 Minimum Dat	a
	assessment v	was not maintained			Set Assessments were	.
	on the chart	or accessible to all			immediately printed and place on Resident #33's clinical reco	
	1				and made accessible to all	, iu
	professional	Stall.			professional staff members.	
					· Completed 3.0 Minimum Dat	a
	13. On 2/22	/11 at 3:00 p.m.,			Set Assessments were immediately printed and place	d
	Resident #33	3's clinical record			on Resident #87's clinical reco	
		d. A 3.0 Minimum			and made accessible to all professional staff members.	
	was reviewe	u. A 3.0 Millillillillill			אוסופסטוטוומו טנמוו ווופוווטפוט.	
					<u> </u>	

l i i		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155757	B. WING	·		02/25/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
BOOLO	XTE VIII A OF LLO				OSEGATE DR		
ROSEGATE VILLAGE LLC			INDIAN	APOLIS, IN46237			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	"	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	COMPLETION DATE
1710				mo	Completed 3.0 Minimum Dat	a	DAIL
	Data Set Ass	,			Set Assessments were		
	completed of	n 1/27/11, was on			immediately printed and place		
	the record.				on Resident #49's clinical reco	ora	
					professional staff members.		
	701 A 1				Completed 3.0 Minimum Dat	a	
	The Adminis				Set Assessments were immediately printed and place	. l	
	interviewed	on 2/22/11 at 9:45			on Resident #36's clinical reco		
	a.m. The Ac	lministrator			and made accessible to all		
	indicated the	e completed			professional staff members. · Completed 3.0 Minimum Dat	,	
		•			Set Assessments were	۵	
	assessments	had not been			immediately printed and place		
	maintained of	on the chart prior to			on Resident #45's clinical reco	ord	
	the day befo	re when all			and made accessible to all professional staff members.		
	1	were printed and			· Completed 3.0 Minimum Dat	a	
		_			Set Assessments were	.	
	placed on the	e clinical records			immediately printed and place on Resident #39's clinical reco		
	by facility cl	noice.			and made accessible to all	,,,,	
					professional staff members. F		
	TTI A .I				will you identify other reside	nts	
		strator indicated			having the potential to be affected by the same deficier	,,	
	Section A [Id	dentification			practice and what corrective	"	
	Information 1	, Section V [Care			action will be taken?		
	Area Assessi	-			· Completed 3.0 Minimum Dat Set Assessments were	a	
		,			immediately printed and place	_d	
		nd Section Z			on all residents' clinical record		
	[Assessment	Administration]			and made accessible to all		
	had been pla	aced on the clinical			professional staff members. What measures will be put in	_{to}	
	_	ections B [Hearing,			place or what systemic		
		L 0,			changes you will make to		
	Speech, and	Vision,] Section C			ensure that the deficient		
	Cognitive P	atterns], Section D			practice does not recur? · Facility has eliminated the us	ا ،	
		<u> </u>			. domey had diffiniated the de		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155757	B. WIN			02/25/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN46237				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Section F [P] Customary F Activities], S [Functional S [Bladder and [Active Diag [Health Con- [Swallowing Status], Sect Status] Secti Conditions], [Medications [Special Trespecial Trespec	Section G Status], Section H d Bowel], Section I gnoses], Section J ditions], Section K g/Nutritional ion L [Oral/Dental on M [Skin Section N s], Section O atments, and Programs,] estraints], Section tion in Assessment tting], had not until ion with surveyors. //11 at 11:20 a.m., //2's clinical record d. A 3.0 Minimum			of the Electronic Storage of M (Minimum Data Set) policy. Facility practice has been revised so that completed 3.0 Minimum Data Set Assessment will be printed and placed on a residents' clinical records and made accessible to all professional staff members. MDS staff and other professional staff will be educated on the revised facility practice. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be printo place? A CQI tool will be utilized by MDS. Coordinator/designee to monic compliance with printing and making accessible completed MinimumData Set Assessment weekly x 4 weeks, monthly x2 months and quarterly thereafter. Results of the audit will be presented to the CQI Committed monthly to ensure compliance and follow-up. Identified noncompliance may result in stre-education and/or disciplinatication.	nts all ated . re t ut e tor 3.0 tts er.	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPI		
		155757	B. WII			02/25/2011	
	PROVIDER OR SUPPLIER		•	7510 RC	DDRESS, CITY, STATE, ZIP CODE DSEGATE DR APOLIS, IN46237	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	the record.						
	a.m. The Adindicated the assessments maintained of the day before assessments placed on the by facility of the Administration A [Identification of the Administration of the Adm	on 2/22/11 at 9:45 dministrator e completed had not been on the chart prior to re when all were printed and e clinical records noice. strator indicated dentification l, Section V [Care					

PRINTED: 04/08/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE S COMPL 02/25/2	ETED	
	PROVIDER OR SUPPLIER		p. WII	STREET A	DDRESS, CITY, STATE, ZIP CODE DSEGATE DR APOLIS, IN46237	<u>I</u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Customary F						
	Activities], S						
	-	Status], Section H					
	-	l Bowel], Section I					
	-	gnoses], Section J					
	-	ditions], Section K					
	[Swallowing/Nutritional						
	Status], Section L [Oral/Dental						
	Status] Section M [Skin						
	Conditions],	Section N					
	[Medication:	s], Section O					
	[Special Trea	atments,					
	Procedures,	and Programs,]					
	Section P [R	estraints], Section					
	Q [Participat	tion in Assessment					
	and Goal Set	tting], had not until					
	after discuss	ion with surveyors.					
		-					
	15. On 2/25	/11 at 10:45 a.m.,					
	Resident #36	6's clinical record					
	was reviewe	d. A 3.0 Minimum					
	Data Set Ass						
		n 1/7/11, was on					
	the record.	,					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2011		
	PROVIDER OR SUPPLIER	!!	7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR IAPOLIS, IN46237	'	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE .	(X5) COMPLETION DATE
	The Adminis	strator was				
		on 2/22/11 at 9:45				
	a.m. The Ac					
	indicated the	-				
		had not been				
		on the chart prior to				
	the day befo					
		were printed and				
	1 ^	e clinical records				
	by facility cl	noice.				
	The Adminis	strator indicated				
		dentification				
	_	, Section V [Care				
	_	ment (CAA)				
		nd Section Z				
		t Administration]				
	<u> </u>	aced on the clinical				
	_	ections B [Hearing,				
	Speech, and	Vision,] Section C				
	Cognitive P	Patterns], Section D				
	_	tion E [Behavior],				
	Section F [P	references for				
	Customary I	Routine and				
	Activities], S	Section G				

011149

PRINTED: 04/08/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757 A. BUILDING B. WING		NSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2011				
	PROVIDER OR SUPPLIEF		B. WIN	STREET A	DSEGATE DR APOLIS, IN46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤΕ	(X5) COMPLETION DATE
	[Functional	Status], Section H					
	-	d Bowel], Section I					
	`	gnoses], Section J					
	-	ditions], Section K					
	[Swallowing	g/Nutritional					
	Status], Sect	tion L [Oral/Dental					
	Status] Sect	ion M [Skin					
	Conditions],	Section N					
	[Medication	s], Section O					
	[Special Tre	atments,					
	Procedures,	and Programs,]					
	Section P [R	testraints], Section					
	Q [Participa	tion in Assessment					
	and Goal Se	tting], had not until					
	after discuss	sion with surveyors.					
	16. On 2/25	/11 at 12:40 p.m.,					
	Resident #4:	5's clinical record					
	was reviewe	ed. A 3.0 Minimum					
	Data Set Ass	sessment,					
	completed o	n 12/21/10, was on					
	the record.						
	The Admini	strator was					
	interviewed	on 2/22/11 at 9:45					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EQ7B11 Facility ID:

011149

If continuation sheet

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		NSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1 = 5, = 5	
NAME OF F	PROVIDER OR SUPPLIER			7510 R	OSEGATE DR		
	ATE VILLAGE LLC			INDIAN	APOLIS, IN46237		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	a.m. The Ac	dministrator					
	indicated the	e completed					
	assessments	had not been					
	maintained of	on the chart prior to					
	the day befo	re when all					
	assessments	were printed and					
	placed on the	e clinical records					
	by facility cl	noice.					
	The Adminis	strator indicated					
	Section A [Id	dentification					
	Information]	, Section V [Care					
	Area Assessi	ment (CAA)					
	Summary, a	nd Section Z					
	[Assessment	Administration]					
	had been pla	ced on the clinical					
	record but S	ections B [Hearing,					
		Vision, Section C					
		atterns], Section D					
	-	tion E [Behavior],					
		references for					
	Customary F	Routine and					
	Activities], S	Section G					
	[Functional	Status], Section H					
	Bladder and	d Bowel], Section I					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EQ7B11 Facility ID:

011149

If continuation sheet

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PRINTED: 04/08/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPL		
		155757	B. WIN			02/25/2	011
NAME OF I	PROVIDER OR SUPPLIER	. {	_		DDRESS, CITY, STATE, ZIP CODE		
ROSEGA	ATE VILLAGE LLC			1	OSEGATE DR APOLIS, IN46237		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	DATE
	[Active Diag	gnoses], Section J					
	[Health Con	ditions], Section K					
	[Swallowing	g/Nutritional					
	Status], Sect	tion L [Oral/Dental					
	Status] Secti	ion M [Skin					
	Conditions],						
	[Medication	s], Section O					
	[Special Tre	atments,					
	Procedures,	and Programs,]					
	Section P [R	Restraints], Section					
	Q [Participa	tion in Assessment					
	and Goal Se	tting], had not until					
	after discuss	sion with surveyors.					
	 17 On 2/25	5/11 at 1:20 p.m.,					
		9's clinical record					
	l	ed. A 3.0 Minimum					
	Data Set Ass						
		on 12/17/10, was on					
	the record.	11 12/17/10, Was on					
	The Adminis	strator was					
	interviewed	on 2/22/11 at 9:45					
	a.m. The Ac	dministrator					
	indicated the						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EQ7B11

Facility ID:

011149

If continuation sheet

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		INSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2011	
NAME OF F	DDOVIDED OF GUIDNI 15D		B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER			1	OSEGATE DR		
	ATE VILLAGE LLC	TATEMENT OF DEFICIENCIES		ID	APOLIS, IN46237		(V5)
(X4) ID PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	∆TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		had not been					
		on the chart prior to					
	the day before	re when all					
	assessments	were printed and					
	placed on the	e clinical records					
	by facility cl	noice.					
	The Adminis	strator indicated					
	Section A [Id	dentification					
	Information]	, Section V [Care					
	Area Assessi	ment (CAA)					
	Summary, a	nd Section Z					
	[Assessment	Administration]					
	had been pla	ced on the clinical					
	record but So	ections B [Hearing,					
	Speech, and	Vision, Section C					
	•	Patterns], Section D					
		tion E [Behavior],					
		references for					
	Customary F						
	Activities], S						
		Status], Section H					
	-	d Bowel], Section I					
	-	gnoses], Section J					
	-	ditions], Section K					
	Lizani Con						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757		(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2011		
	PROVIDER OR SUPPLIER	!!	STREET A 7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR APOLIS, IN46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	[Swallowing	g/Nutritional				
	Status], Sect	tion L [Oral/Dental				
	Status] Secti	ion M [Skin				
	Conditions],	Section N				
	[Medication	s], Section O				
	[Special Tre	atments,				
	Procedures,	and Programs,]				
	=	estraints], Section				
	Q [Participa	tion in Assessment				
	and Goal Se	tting], had not until				
	after discuss	ion with surveyors.				
	Procedure titled 'MDS (Minimum D on 2/21/11 at 3 p.i item sets will be swithin current so sets are accessible individualized us MDS 3.0 item sets to staff (including agencies (includiothers who are anneed to review the provide care to the MDS data will be 15 months of electromainder of the	be printed and stored in				

l		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	(X2) MULTIPLE CC A. BUILDING B. WING	JNSTRUCTION	COMP. 02/25/2	LETED
	PROVIDER OR SUPPLIER		STREET A 7510 R	ADDRESS, CITY, STATE, ZIP CODE COSEGATE DR JAPOLIS, IN46237	_ E	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
-						

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2011	
	PROVIDER OR SUPPLIER			7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR IAPOLIS, IN46237		
ROSEGA (X4) ID PREFIX TAG F0315 SS=E	PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 3. On 2/21/11 at 11:30 a.m. during initial tour, Resident #1 was observed to have a Foley catheter. On 2/24/11 at 11:30 a.m., Resident #1 was observed to be transferred by CNAs #11 and #12. When the resident was lifted from the wheelchair seat, the Foley catheter tubing was positioned under the resident's right leg. An indentation was observed on the resident's posterior right thigh. The CNAs placed the Foley catheter bag on the resident's abdomen (above the bladder level) during the transfer. The resident was provided incontinence care. The Foley catheter tubing was observed not to		F03	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 Foley catheter tubing was immediate secured to his leg. Resident's care plans were updated to rethese needs. Resident #3 no longer resides at the facility. Resident #87 Foley catheter tubing was immediately secure to his leg. Resident's care plan were updated to reflect these needs. Resident #36 was monitored by nursing staff with signs or symptoms of infection noted. Immediate training was immediate training was immediate training was monitored.	l ely flect ed ens	(X5) COMPLETION DATE 03/27/2011
	be secured the recatheter tubing merosion. Review of the cli #1 on 2/21/11 at physician's order February 2011 pl Foley catheter casure secured to leplan of care dated resident requires catheter related to and Paraplegic. 4. On 2/23/11 at was observed to	nical record of Resident 2:30 p.m. indicated a dated 12/10/10 on the hysician order sheet of re every shift and make eg via strap. A current d 12/22/10 was noted of an indwelling urinary o Neurogenic Bladder, 9:55 a.m., Resident #3 be in bed. The resident's bing was observed to be			completed to educate nursing staff on securing Foley catheter tubing and keeping catheter below the bladder level with transfers. How will you ident other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents identified a Foley catheters will have the Foley catheter tubing secured all times. Residents identified with Foley catheters will have catheter bag below bladder lewith all transfers. Residents requiring a change between For catheter bag and a Foley leg be will have aseptic technique followed. What measures will be put into place or what systemic changes you will make to ensure that the	er ags ify e with at the the vel oley oag	

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED 02/25/2011
	PROVIDER OR SUPPLIER		7510 F	ADDRESS, CITY, STATE, ZIP CODE ROSEGATE DR NAPOLIS, IN46237	02/20/2011
(X4) ID PREFIX TAG	summary's (EACH DEFICIEN REGULATORY OR placed over the s bed. On 2/23/11 was observed to care by CNAs #6 Foley catheter was secured to the residenter tubing merosion. The resit the incontinence catheter tubing was observed to wheelchair to be lift by CNAs #11 transfer, the Fole urine was observed resident's abdom resident's bladde tubing was observed the resident's leg Review of the cli #3 on 2/24/11 at physician's order while IV hydration Interview of the Services on 2/25. Foley catheter ba maintained below secured to prevent information not contained.	nical record of Resident 3:35 p.m. indicated a of "please anchor Foley	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) deficient practice does not recur? Residents with new physician orders for Foley catheters will have the Foley catheter tubing secured and maintained below bladder lew with transfers. Nursing staff be educated on Foley cathete care including aseptic techniq and maintenance. How the corrective action (s)will be monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place. A CQI tool will be utilized by Nurse Managers to monitor compliance with securing Fole catheter tubing and keeping catheter bags below bladder I with transfers related to reside with Foley catheters weekly x weeks, monthly x2 months and quarterly thereafter. Results the audit will be presented to CQI Committee monthly to ensure compliance and follow Identified noncompliance may result in staff re-education and disciplinary action.	el will er uue cur, ce? evel ents 4 ad of the

Facility ID:

l	OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	A. BUILDING B. WING		COMP	(x3) DATE SURVEY COMPLETED 02/25/2011	
	PROVIDER OR SUPPLIER		STREET 7510 F	TADDRESS, CITY, STATE, ZIP CO ROSEGATE DR NAPOLIS, IN46237	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	procedure titled 'Maintenance" da 11 a.m., indicated providing cathete	cility current policy and 'Foley catheter care and ted 1/2010, on 2/25/11 at d "Procedure for er care8. Prevent from er as much as possible dure"					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155757	A. BUII B. WIN			02/25/2011	
	PROVIDER OR SUPPLIER			7510 R	ADDRESS, CITY, STATE, ZIP CODE ROSEGATE DR NAPOLIS, IN46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
F0315	Based on ob	servation,	F03	15	What corrective action(s) wil	03/27/2011	
SS=E		d record review,			be accomplished for those residents found to have been	ո	
	the facility fa	ailed to maintain			affected by the deficient practice? • Resident #1 Foley		
	urinary drain	nage catheters in a			catheter tubing was immediate secured to his leg. Resident's		
	manner to pr	revent urinary tract			care plans were updated to re	flect	
	infections fo	r 4 of 4 residents			these needs. · Resident #3 no longer resides at the facility.		
	reviewed in	a sample of 24			· Resident #87 Foley catheter		
	with indwell	ing catheters in			tubing was immediately secure to his leg. Resident's care plan		
	that drainage	e bags were not			were updated to reflect these needs. · Resident #36 was		
	maintained b	elow bladder			monitored by nursing staff with		
	level, cathete	ers were not			signs or symptoms of infection noted. Immediate training w		
	secured to pr	revent urethral			completed to educate nursing		
	irritation, and	d handwashing			staff on securing Foley cathete tubing and keeping catheter be		
		ntained during			below the bladder level with transfers. How will you ident	ify	
		n of leg bag and			other residents having the	""	
		bladder irrigation			potential to be affected by th	e	
		ontamination.			same deficient practice and what corrective action will be		
	•				taken? · Residents identified	with	
	[Residents #	87, #36, #1, #3]			Foley catheters will have the Foley catheter tubing secured	at	
	T. 1	1 1			all times. Residents identified		
	Findings inc	lude:			with Foley catheters will have catheter bag below bladder le		
					with all transfers. Residents requiring a change between F	olev	
	1. During in	itial tour on			catheter bag and a Foley leg b	· 1	
	2/21/11 which	ch began at 11:15			will have aseptic technique followed. What measures wil	,	
	a.m., with th	e Assistant			be put into place or what	.	
	Director of N	Nursing [ADNS]			systemic changes you will make to ensure that the		

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Event ID:

EQ7B11 Facility ID:

011149

If continuation sheet

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15575	57 L	FICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION LECTION IDENTIFICATION NUMBER: A. BUILDING		COMPLETED
		B. WING		02/25/2011
NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE LLC		7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR APOLIS, IN46237	
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEN	BE PERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
Resident #87 was utilizing an indwe catheter. On 2/22/11 at 11:2 CNAs #2 was obs provide pericare to #87 and LPN #1 was to provide a treatmer resident's coccyx are ident was turned forth during the case of Foley catheter was not to be attached tension and irritation urethra during the case of the foley catheter was not a stacked tension and irritation and irritation and irritation and irritation and #18 were transfer Resident and #18 were transfer Resident and wheelchair to be mechanical lift. It transfer, the CNA observed to handled drainage bag, raise	identified as elling Foley 25 a.m., served to o Resident was observed ment to the area. The ed back and are. The es observed to prevent ion to the e care. 0 p.m., CNAs observed to #87 from the with a During the es were et the urinary		deficient practice does not recur? Residents with new physician orders for Foley catheters will have the Foley catheter tubing secured and maintained below bladder leve with transfers. Nursing staff be educated on Foley catheter care including aseptic techniquand maintenance. How the corrective action (s)will be monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place. A CQI tool will be utilized by Nurse Managers to monitor compliance with securing Fole catheter tubing and keeping catheter bags below bladder lewith transfers related to reside with Foley catheters weekly xaweeks, monthly x2 months and quarterly thereafter. Results the audit will be presented to the CQI Committee monthly to ensure compliance and follow-Identified noncompliance may result in staff re-education and disciplinary action.	will r ue ur, e? y evel ents 4 d of he -up.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155757	B. WIN	IG		02/25/2	011
	PROVIDER OR SUPPLIER		•	7510 RG	DDRESS, CITY, STATE, ZIP CODE DSEGATE DR APOLIS, IN46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
	resident's he	ad during the					
	transfer, and after positioning						
	the resident	in bed, laid the					
	drainage bag	g on top of the					
	mattress whi	ile removing the lift					
	sling from u	nderneath the					
	resident. Th	e Resident was					
	turned back	and forth during					
	the procedure, and the catheter						
	was observe	d not to be secured					
		nsion and irritation					
	to the urethra						
		•••					
	2 During in	nitial tour with RN					
	•	1 at 11:05 a.m.,					
		6 was identified as					
		indwelling Foley					
	_	leg bag with an as					
		inuous bladder					
		illuous blauuci					
	irrigation.						
	On 2/25/11 s	at 12:00 p.m., RN					
		erved to disconnect					
		6's leg bag from the					
		er, attach a regular					
	Torcy camet	ci, anacii a regulal					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2011		
	ROVIDER OR SUPPLIER	!!	7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR IAPOLIS, IN46237	-1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	-	nage bag, and				
		tinuous bladder				
	•	oing to the Foley N#16 put on a				
		Sigloves, moved the				
	•	ation pole from				
	•	he bed to the other.				
		ne gloves on RN				
		ected the leg bag,				
		catheter with an				
	•	attached a new g, cleansed the end				
		tubing with an				
		with same gloves				
	on, changed	the left glove and				
	opened the r	oller clamp to the				
	•	oing with the right				
	hand.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155757	B. WIN			02/25/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN46237				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDENCE N. AN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
F0323	Based on ob	servation,	F03	23	What corrective action(s) will be accomplished for those	03/27/2011	
SS=E	interview, ar	nd record review,			residents found to have been	ո	
	the facility fa	ailed to ensure a			affected by the deficient practice? Immediate training	,	
	safe environ	ment in that 4 of 4			was completed to educate		
	residents in a	a sample of 24			nursing staff on proper transfe with mechanical lifts in	rs	
	[Residents #	87, #1, #3, # 133]			accordance with manufacture		
	were observe	ed not to be			guidelines. · Resident #87 was immediately repositioned in be		
	transferred w	vith mechanical			with one-quarter side rails in raised position. The coffee p	ot	
	lifts in accor	dance with			hot plate and toaster were		
		rs' directions; 1 of			removed from resident access areas in the Memory Care	sible	
		ŕ			activity/diningroom. · Residen		
	•	resident on an air			#87, 1, 3, and 133 showed no injuries or signs/symptoms of		
	alternating n				psychosocial distress after		
	observed wit	th parts of the body			mechanical lift transfers. How		
	extending ov	ver the edge of the			will you identify other reside having the potential to be	nts	
	mattress in a	sample of 24; and			affected by the same deficien	nt	
	22 of 34 resi	*			practice and what corrective		
ı					action will be taken? · All residents currently being		
	memory care				transferred using the Invacare		
		the dining/activity			Reliant 450 or the Lumex LFI1050 Patient Lift have been	,	
	area unsuper	vised with a hot			identified. Nursing staff have	·	
	pot of coffee	e, a hot plate and			been in-serviced on the prope	r	
	toaster acces	sible to residents			use of mechanical lifts in accordance with the		
	on the count	er.			manufacturer's guidelines. Residents who are coded as		
					dependent have been identifie		
	Findings inc	lude:			and observed for proper bed positioning. All nursing and		
	1 mamgs me	1440.			licensed staff have been		
					in-serviced on the importance	of	
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID: E	 EQ7B11	Facility	ID: 011149 If continuation s	heet Page 51 of 80	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		155757	A. BUII B. WIN	LDING		02/25/2011	
		II .	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2			OSEGATE DR		
	ATE VILLAGE LLC			INDIAN	IAPOLIS, IN46237		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E	LETION ATE
1110		nitial tour on			proper bed positioning and sa		
	2/21/11 at 11:45 a.m., with the				 Safety assessments of all resident dining areas have be 	en	
		rector of Nursing			done. All potential burn hazard have been removed from area	ls	
		DNS] Resident #87			accessible to residents. What	-	
		-			measures will be put into pla	- I	
	was observe				or what systemic changes yo	ou	
	alternating r	nattress, with two			will make to ensure that the deficient practice does not		
	one quarter	siderails in the			recur? · Skills validations will	oe	
	1 ^	ition. The head of			conducted for all CNA staff on		
	1				usage of mechanical lifts including compliance with		
		s bed was elevated			manufacturer's guidelines. · S	kills	
	45 degrees,	with a tube feeding			validations will be conducted f	or	
	infusing thro	ough a feeding			all CNA staff on dependent resident bed positioning include	ina	
	1	DNS identified the			safe body alignment. Nursing	,	
					staff orientation will include sk	-	
		aving quadriplegia,			validations for the proper usage of mechanical lifts (including	e	
	traumatic br				manufacturer's guidelines) an	d	
	continuous t	tube feeding and			dependent resident bed positioning. · Hot coffee pot a	and	
	tracheostom	y, and open area on			warmer will be replaced by die		
	the coccyx.	J			department. Coffee will be	´	
	ine coccyx.				provided to memory care residents in carafes. Toaster in	,	
					memory care dining room has	'	
	On 2/22/11 a	at 11:25 a.m., the			been secured in employee on		
	ADNS and	CNAs #2 were			area and utilized in secured and when needed. How the	ea	
	observed to	position Resident			corrective action (s) will be		
	#87 on his le	eft side to provide			monitored to ensure the deficient practice will not rec	ur.	
		the resident was			i.e., what quality assurance		
	observed to	be on the edge of			program will be put into place A CQI audit tool will be utilized.		
		nating mattress and			to monitor compliance with prousage of mechanical lifts.	- I	
					adage of meditalilear into.		
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	EQ7B11	Facility	ID: 011149 If continuation s	neet Page 52 o	of 80

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		155757	A. BUI B. WIN	LDING IG		02/25/2011
NAME OF F	PROVIDER OR SUPPLIER		p. ,, n.	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
	ATE VILLAGE LLC			1	OSEGATE DR APOLIS, IN46237	
(X4) ID		TATEMENT OF DEFICIENCIES	_	ID	The Octo, 14-0207	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	Desident transfers using	DATE
	_	with splints on, to			Resident transfers using mechanical lifts will be observed	ed
	be extended	over the edge of			weekly X 4 weeks, monthly X in months and quarterly thereafter	
	the bed during	ng the care. After			A CQI audit tool will be utilize	ed
	completion of	of the ADL			to monitor compliance with probed positioning of dependent	pper
	[activities of	daily living] care			residents. Resident observation	ons
	LPN #4 was	observed to			will be completed weekly X 4 weeks, monthly X 2 months ar	nd
	provide a dre	essing change to			quarterly thereafter. A CQI at tool will be utilized to monitor	•
	the resident's	s coccyx. Prior to			compliance with resident safet	y in
	the dressing	change, LPN #4			the Memory Care unit. Dining room observations will be done	۵
	_	scoot the resident			weekly X 4 weeks, monthly X	2
	-	to avoid being so			months and quarterly thereafter Results of these evaluation	er.
		edge of the bed.			processes will be presented to	
		ougo or the out.			the CQI Committee monthly to review for compliance and)
	 On 2/23/11 s	at 10:45 a.m.,			follow-up. Identified noncompliance may result in s	toff
		7 was observed in			re-education and/or disciplinar	
					action.	
		ir alternating				
		vo one-quarter				
		re observed on the				
		wered position.				
	The resident	's head of bed was				
		degrees, and the				
	pillow, and l	eft shoulder were				
	on the edge	of the bed and				
	extended over	er the edge of the				
	mattress.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN46237				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
	was reviewed 1:45 p.m. To diagnosis inclimited to, qualification A Minimum assessment, 6/21/10, code required total for bed mobe assessment in were utilized. A plan of call addressed the bedrails to provide involuntary storming, in side, decortion positioning/plantervention not limited to the storming of the storming	Data Set [MDS] completed on led the resident as all assistance of two ility. The indicated bed rails d for mobility. The indicated bed rails defor mobility.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COME	(X3) DATE SURVEY COMPLETED 02/25/2011	
	PROVIDER OR SUPPLIER		STREET A 7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR APOLIS, IN46237	I	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	noted for on to be in side physician's of A side rail as completed of the use of side tactile bed be sensory defined accidental room accidental room accidental room accidental room by the DON p.m., included limited to, "Edge. The Fifthe Stage IV (LS) is engined form or compressure. The	n 1/21/11 indicated derails provides oundaries with cits or poor muscle to prevent				

011149

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155757	B. WING			02/25/2	011
	PROVIDER OR SUPPLIER		•	7510 R	DDRESS, CITY, STATE, ZIP CODE DSEGATE DR	•	
	ATE VILLAGE LLC			L .	APOLIS, IN46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤΕ	(X5) COMPLETION DATE
	the critical s	afety area of the					
	mattress, between the edge of						
	the bed and	the siderails,					
	dramatically	reducing the risk					
	of patient fal	lls and					
	entrapment.'	1					
		11 at 12:35 p.m. on					
	the memory care unit, 22 of 34						
	residents of	the unit were					
	observed in	the dining/activity					
	room withou	it staff supervision.					
	A coffee mal	ker was observed					
	on the count	er area of the unit,					
	accessible to	the residents, with					
	a full pot of	hot coffee on. A					
	hot plate and	l toaster were also					
	observed on	the counter					
	plugged in a	nd operational					
	when switch	ed on. A					
	housekeeper	was observed at					
	the opposite	end of the room					
	with her bac	k to the residents					
	sweeping. N	Nursing staff were					
	not observed	l in the room.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155757	B. WING			02/25/2	011
	PROVIDER OR SUPPLIER		•	7510 RC	DDRESS, CITY, STATE, ZIP CODE DSEGATE DR APOLIS, IN46237	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	was intervied 12:40 p.m. It the coffee can filled after later for residents indicated the staff are not she could not resident might cup of coffee 3. On 2/24/2 CNAs #17 and observed to #87 from the with the Invented in the staff are not she could not resident might cup of coffee 3. On 2/24/2 CNAs #17 and observed to #87 from the with the Invented in the staff are changed in the staff are sident's change of the staff are not she could not resident and the staff are not she could not resident and the staff are not she could not resident and the staff are not she could not resident and the staff are not she could not resident and the staff are not she could not resident and the staff are not she could not resident and the staff are not she could not resident and the staff are not she could not resident and the staff are not she could not resident and the staff are not she could not resident and the staff are not she could not resident and the staff are not she could not resident and the staff are not she could not resident and the staff are not she could not resident and the staff are not she could not resident and the staff are not she could not resident and the staff are not she could not resident and the staff are not she could not resident and the staff are not she could not resident and the staff are not she could not she	ere are times when in the room and of say that no ht try to pour self a e. 11 at 3:10 p.m., and #18 were transfer Resident e wheelchair to bed acare 450 lift.					

		IDENTIFICATION NUMBER:			NSTRUCTION	i 1	(X3) DATE SURVEY COMPLETED	
I I D I DI III	or conduction	155757		JILDING			2/25/2011	
			B. WI		DDRESS, CITY, STATE, ZIP			
NAME OF I	PROVIDER OR SUPPLIER	t .			OSEGATE DR	CODE		
ROSEGA	ATE VILLAGE LLC			1	APOLIS, IN46237			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX TAG	*	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	HE APPROPRIATE	COMPLETION DATE	
	chair, and th	e CNAs continued						
	to raise the r	esident higher.						
	The resident's head was							
	observed to be higher than the							
	CNAs. While perpendicular to							
	the lift mast,	, the resident was						
	transferred f	rom the wheelchair						
	to the bed in	the elevated						
	position. The base of the lift							
	was closed a	and positioned						
	under the be	•						
		lowered into the						
	bed.							
	Resident #87	7's clinical record						
	was reviewe	ed on 2/21/11 at						
	1:45 p.m. T	he resident's						
	diagnosis inc	cluded, but was not						
	_	uadriplegia. A						
		ata Set [MDS]						
		completed on						
	6/21/10, cod	led the resident as						
	non-ambulat	tory, required total						
	assistance of	f two for bed						
	mobility and	l transfers. The						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	EQ7B1	1 Facility I	D: 011149 If o	continuation sheet	Page 58 of 80	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2011		
	PROVIDER OR SUPPLIER		7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR APOLIS, IN46237	'	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
		coded the resident mechanical lift.				
	addressed the risk for falls lift for transformation, standards spasms, and regimen. At included but					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/25/2011	
	PROVIDER OR SUPPLIER	2	•	7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR APOLIS, IN46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0323 SS=E	observed to be tr "Invacare Relian CNAs #11 and # transferred from bed. During the telift was open wh closed the base of away from the w was raised 18 independent of the lift re position when tra when the resident bed. Incontinence the resident. The transferred back the Hoyer lift. The transferred back the Hoyer lift. The transferred back the Hoyer lift. The base of the lift w The base remain transported and to of the wheelchair lowered into the Review of the cli #1 on 2/21/11 at physician's order lift to transport re and immobility. 5. On 2/24/11 at	ansferred utilizing the t 450 " Hoyer lift by 12. The resident was the wheelchair to the transfer, the base of the en lifted and the CNAs of the lift after pulled theelchair. The resident ches of the wheelchair d at the high height. The remained in the closed ransported to the bed and at was lowered into the e care was provided to resident was then into the wheelchair with the CNAs lifted the es off of the bed and the reas closed when lifted. The resident was then into the wheelchair with the control of the bed and the resident was then in front the control of the wheelchair. The resident was then seat of the wheelchair. The resident was then seat of the wheelchair.	F03	23	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Immediate training was completed to educate nursing staff on proper transfe with mechanical lifts in accordance with manufacturer guidelines. Resident #87 was immediately repositioned in be with one-quarter side rails in raised position. The coffee phot plate and toaster were removed from resident access areas in the Memory Care activity/diningroom. Resident #87, 1, 3, and 133 showed no injuries or signs/symptoms of psychosocial distress after mechanical lift transfers. How will you identify other resident having the potential to be affected by the same deficier practice and what corrective action will be taken? All residents currently being transferred using the Invacare Reliant 450 or the Lumex LFI1050 Patient Lift have been identified. Nursing staff have been in-serviced on the proper use of mechanical lifts in accordance with the manufacturer's guidelines. Residents who are coded as dependent have been identified and observed for proper bed positioning. All nursing and licensed staff have been in-serviced on the importance	rs 's sed ot, ible nts	03/27/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED	
		155757		B. WING 02/25/2011			
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	₹					
DOCEC	ATE \/// A OE O			1	OSEGATE DR		
RUSEGA	ATE VILLAGE LLC			INDIAN	IAPOLIS, IN46237		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(.	X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	E COMP	LETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DA	TE
	wheelchair to the	e bed utilizing the			proper bed positioning and sa	ety.	
	"Invacare Relian	at 450" Hoyer lift by			· Safety assessments of all		
		12. The resident was			resident dining areas have be		
		wheelchair seat 15 inches.			done. All potential burn hazard		
					have been removed from area	s	
		nained at the same high			accessible to residents. What		
	height during the transfer. The base of the				measures will be put into pla or what systemic changes yo	I .	
	lift was opened when lifted and remained				will make to ensure that the	'u	
	open until reaching the bed. The base was				deficient practice does not		
	1 ^	under the bed and then			recur? · Skills validations will	ne	
	only opened slightly when under the bed.				conducted for all CNA staff on		
					usage of mechanical lifts		
	The resident was lowered with the base				including compliance with		
	only opened slig	htly.			manufacturer's guidelines. · S	kills	
					validations will be conducted f	or	
	Review of the cl	inical record on 2/24/11			all CNA staff on dependent		
	at 3:35 p.m. indi	cated a physician's order			resident bed positioning include		
	_	resident up in the			safe body alignment. Nursing		
		Hoyer lift at least one hour			staff orientation will include sk	 	
	_	-			validations for the proper usage	e	
	-two hours to rec	ceive inerapy.			of mechanical lifts (including manufacturer's guidelines) and	,	
					dependent resident bed	'	
	Review of the m	anufacturer's guidelines			positioning. · Hot coffee pot a	ind	
	for the "Invacare	e" Hoyer lift, on 2/25/11 at			warmer will be replaced by die	I .	
	11:15 a.m., indic	ated "LIFTING THE			department. Coffee will be	·	
	· ·	e legs of the lift must be			provided to memory care		
		open position and the			residents in carafes. Toaster in	1	
	shifter handle lo	* *			memory care dining room has		
		-			been secured in employee onl	•	
	_	y and safety. If it is			area and utilized in secured ar	ea	
		se the legs of the lift to			when needed. How the corrective action (s) will be		
	maneuver the lif	t under a bed, close the			monitored to ensure the		
	legs of the lift or	nly as long as it takes to			deficient practice will not rec		
	position the lift of	over the patient and lift			i.e., what quality assurance	~··,	
	1 ^	•			program will be put into place	_{e?}	
	the patient off the surface of the bed. When the legs of the lift are no longer				· A CQI audit tool will be utilize	 	
	_				to monitor compliance with pro	I	
	under the bed, re	eturn the legs of the lift to			usage of mechanical lifts.	·	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S		URVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPLI	ETED
		155757	B. WING			02/25/20	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	C		7510 R	OSEGATE DR		
	ATE VILLAGE LLC				APOLIS, IN46237		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	_	en position and lock the			Resident transfers using mechanical lifts will be observ	_h_	
	shifter handle				weekly X 4 weeks, monthly X		
	-	fting/Moving the			months and quarterly thereaft		
	Patient1. Pum	p the lift handle or press			A CQI audit tool will be utilize		
	the UP button to	raise the patient above			to monitor compliance with pro	oper	
	the bed. The pati	ient should be elevated			bed positioning of dependent residents. Resident observati	000	
	high enough to c	clear the bed with their			will be completed weekly X 4	0115	
	weight fully sup	ported by the lift3.			weeks, monthly X 2 months a	nd	
	When the patien	t is clear of the bed			quarterly thereafter. A CQI a		
	•	neir feet off the bed5.			tool will be utilized to monitor		
		ne patient away from the			compliance with resident safe	ty in	
		ient so that he/she faces			the Memory Care unit. Dining room observations will be don	_	
		ing the patient lift. 6.			weekly X 4 weeks, monthly X		
	-	N buttonlowering the			months and quarterly thereaft		
		s feet rest on the base of			Results of these evaluation		
	•				processes will be presented to		
	•	g the mast NOTE: The			the CQI Committee monthly to	·	
	`	gravity provides stability			review for compliance and follow-up. Identified		
		ent feel more secure and			noncompliance may result in s	staff	
	the lift easier to	move"			re-education and/or disciplina		
					action.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757 A. BUILDING B. WING			ONSTRUCTION	(X3) DATE S COMPL 02/25/2	ETED		
	PROVIDER OR SUPPLIER			7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR IAPOLIS, IN46237		
ROSEGA (X4) ID PREFIX TAG F0323 SS=E	PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) O323 6. On 2/24/11 at 12 noon, CNAs #'s 21		F03	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Immediate training was completed to educate nursing staff on proper transfer with mechanical lifts in accordance with manufacturer guidelines. Resident #87 was immediately repositioned in be with one-quarter side rails in raised position. The coffee po	rs 's	(X5) COMPLETION DATE 03/27/2011
	provided on 2/25 Documentation i not lock the brak when lifting. Th to roll to allow the itself when the pa				hot plate and toaster were removed from resident access areas in the Memory Care activity/diningroom. Resident #87, 1, 3, and 133 showed no injuries or signs/symptoms of psychosocial distress after mechanical lift transfers. How will you identify other resider having the potential to be affected by the same deficier practice and what corrective action will be taken? All residents currently being transferred using the Invacare Reliant 450 or the Lumex LFI1050 Patient Lift have been identified. Nursing staff have been in-serviced on the proper use of mechanical lifts in accordance with the manufacturer's guidelines. Residents who are coded as dependent have been identifie and observed for proper bed positioning. All nursing and licensed staff have been in-serviced on the importance	ible nts d	

	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 155757	A. BUILDING	UNSTRUCTION	COMPLETED 02/25/2011			
		100707	B. WING	ADDRESS CITY STATE ZIR CORE	02/20/2011			
NAME OF F	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR					
	TE VILLAGE LLC		INDIAN	JAPOLIS, IN46237				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION			
TAG		LSC IDENTIFYING INFORMATION)	TAG	proper bed positioning and sa Safety assessments of all resident dining areas have be done. All potential burn hazar have been removed from area accessible to residents. What measures will be put into pla or what systemic changes y will make to ensure that the deficient practice does not recur? Skills validations will conducted for all CNA staff or usage of mechanical lifts including compliance with manufacturer's guidelines. So validations will be conducted all CNA staff on dependent resident bed positioning inclusiate body alignment. Nursin staff orientation will include should be validations for the proper usage of mechanical lifts (including manufacturer's guidelines) and dependent resident bed positioning. Hot coffee pot warmer will be replaced by didepartment. Coffee will be provided to memory care residents in carafes. Toaster is memory care dining room has been secured in employee on area and utilized in secured a when needed. How the corrective action (s) will be monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place. A CQI audit tool will be utilized to monitor compliance with prusage of mechanical lifts.	fety. en ds as ace ou be ds ding g dills ge d and etary n s ly rea			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING A. BUILDING A. BUILDING			COMPI 02/25/2	LETED		
	PROVIDER OR SUPPLIEF		B. WING OZZZJZ011 STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN46237			
ROSEGA (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) Resident transfers using mechanical lifts will be obsweekly X 4 weeks, monthlymonths and quarterly there. A CQI audit tool will be ut to monitor compliance with bed positioning of dependeresidents. Resident obserwill be completed weekly X weeks, monthly X 2 month quarterly thereafter. A CQI tool will be utilized to monicompliance with residents the Memory Care unit. Din room observations will be weekly X 4 weeks, monthlymonths and quarterly thereafter.	erved y X 2 eafter. tillized proper ent vations (4 s and QI audit tor affety in ing done y X 2 eafter.	(X5) COMPLETION DATE
				· Results of these evaluation processes will be presented the CQI Committee month review for compliance and follow-up. Identified noncompliance may result re-education and/or discipliaction.	ed to ly to in staff	

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757 A. BUILDING B. WING			ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2011		
NAME OF F	PROVIDER OR SUPPLIER			7510 R	ADDRESS, CITY, STATE, ZIP CODE COSEGATE DR		
ROSEGA	TE VILLAGE LLC			INDIAN	IAPOLIS, IN46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
F0332 SS=D	Based on observation interview, the fact was free of a medigreater than 5% for supplemental same Resident #26, and observed receiving errors in medicate 50 opportunities administration. To medication error in medication error Findings include 1. On 2/24/11 at observed to administer medication to administer medication error in medication error	ation, record review, and cility failed to ensure it dication error rate of for 3 of 5 residents in a mple of 5 (Resident #5, d Resident # 133) and medications. Three ion were observed during for error in medication this resulted in a rate of 6 %.	F03		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #26 receives medications per physician orders and administration of medication is given per standards of practice. Resident #5 receives medications per physician order and administration of medicati is given per standards of practice. Resident #133 (should be #receives medications per physician orders and administration of insulin is given with food. How will you ident other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have be identified who have physician orders for medications that cannot be crushed and that require administration of insuling with food. The physician will notified for those residents identified with medications that cannot be crushed to request therapeutic interchanges. Ne residents and existing resident with new physician orders for lot Crush medications have the potential to be affected. These	en en be t w ts Do ne	DATE 03/27/2011
	procedure titled '	cility's current policy and 'Medications that cannot date] on 2/24/11 at 3:40			residents will have physician orders reviewed by nurse management personnel Mond Friday, excluding holidays, to identify physician orders for Do		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EQ7B11 Facility ID: 011149

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		155757	B. WING		02/25/2011
NAME OF I	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	ļ.
NAME OF I	KOVIDER OR SUPPLIER		7510 F	ROSEGATE DR	
	ATE VILLAGE LLC			NAPOLIS, IN46237	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	Not Crush medications.	DATE
	•	Generally, medications		Physician orders will be	
		t be crushed fall into one		obtained for those residents	
	of the following	categories:		indentified to have insulin	
	Extended-release	Extended-release products. The formation		requiring administration with f	ood.
	of some tablets is	of some tablets is specialized as to allow		Licensed nurses will be	
		vithin to slowly release		re-educated on following	
	into the body * Common abbreviations			physician orders by the	
	for Extended-release products:CR			Pharmacist and/or DNS. Wh	
	Controlled releas	•		measures will be put into plants and a second and a second and a second and a second	I
	Controlled release			or what systemic changes y will make to ensure that the	ou
	D : 0.1 00	10.00		deficient practice does not	
	Review of the 2010 "Nursing Spectrum			recur? · Resident's receiving	Do
	_	' on 2/25/11 at 10 a.m.		Not Crush Medications will ha	
	indicated for Sin	emet CR "patient		medication cards and MAR's	
	teaching - Instruc	ct patient to swallow		labeled DO NOT Crush.	
	extended -release	e tablets whole without		· Pharmacist will conduct	
	crushing or chew	ving them"		medication pass audits on thr	ee
	8	8		nurses monthly. Licensed nurses will be educated on ho	nu to
	2 On 2/25/11 at	9:10 a.m., RN # 15 was		identify medications that are r	I
		inister medications to		to be crushed and insulin's th	•
				require administration with foo	
		nurse was observed to		How the corrective action (s)
		cations to Resident #5		will be monitored to ensure	I
		out was not limited to		deficient practice will not re	cur,
	Dynacirc CR 10	mg tablet. The tablet		i.e., what quality assurance	
	was crushed and	provided to the resident		program will be put into place	
	in apple sauce.			· A Physician Order/MAR CQ audit tool will be utilized to rev	
				appropriate identification of	/ICW
	Review of the cli	inical record of Resident		medications that cannot be	
		10: 25 a.m. indicated a		crushed and insulin's that mu	st
		dated 2/15/11 of		be administered with food we	ekly
	^ *			x 4, monthly x2 months and	,
	Dynacife CK 10	milligram everyday.		quarterly thereafter. · Results	
				the audit will be presented to CQI Committee monthly to	ine
		cility's current policy and		ensure compliance and follow	/-up
	procedure titled '	'Medications that cannot		Identified noncompliance may	•

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2011	
	PROVIDER OR SUPPLIER		7510 R	ADDRESS, CITY, STATE, ZIP CODE ROSEGATE DR NAPOLIS, IN46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	p.m. indicated "C which should not of the following Extended-release of some tablets is the medication w into the body * C for Extended-rele Controlled release Review of the 20 Drug Handbook' indicated for Dyn "Administration	e products. The formation is specialized as to allow within to slowly release common abbreviations ease products:CR se" 210 "Nursing Spectrum on 2/25/11 at 10 a.m. maCirc CR - Don't crush or break etablets. Make sure		result in staff re-education and disciplinary action.	d/or and a second a

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIC		COMPL	ETED
		155757	A. BUIL B. WING			02/25/2	011
			B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
DOCECA	TEVULACELLO				OSEGATE DR		
KUSEGA	TE VILLAGE LLC			INDIAN	IAPOLIS, IN46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0332	3. During initial	tour on 2/21/11 which	F03.	32	What corrective action(s) will	l	03/27/2011
SS=D	began at 11:30 a.	m., with LPN #25, the			be accomplished for those		
00-5	-	esident #133 was not			residents found to have beer	1	
	interviewable.	oracine in 199 was nee			affected by the deficient		
	interviewable.				practice? · Resident #26		
	0.00444				receives medications per		
		20 p.m., LPN #23			physician orders and administration of medication is		
	administered 8 ur	nits of Novolog 100/ml			given per standards of practice		
	Insulin to resider	nt #133. The nurse did			Resident #5 receives	. .	
	not offer the resid	dent any food items and			medications per physician orde	ers I	
	moved on to the	-			and administration of medication		
	administer medic				is given per standards of pract		
	administer medic	ations.			Resident # 133 (should be #	116)	
					receives medications per		
	-	resident was observed in			physician orders and		
	the therapy depart	rtment.			administration of insulin is give		
					with food. How will you ident	ify	
	The resident was	questioned as to whether			other residents having the		
		ything since the insulin			potential to be affected by the	е	
	-	ident indicated she could			same deficient practice and		
		ident indicated she could			what corrective action will be		
	not remember.				taken? · All residents have be	en	
					identified who have physician orders for medications that		
	Therapist #24 inc	dicated the resident had			cannot be crushed and that		
	been in the thera	py room for the past 25			require administration of insuli	n l	
		not received any food or			with food. · The physician will		
	drinks while in th	•			notified for those residents		
	drinks wille in ti	стару.			identified with medications that	t	
	D : :	CL DV 1/102 0/04/11			cannot be crushed to request		
	C	of LPN #23, on 2/24/11			therapeutic interchanges. · Ne		
		N indicated the resident			residents and existing resident		
	had snacks in her	r room, but she was			with new physician orders for I		
	unsure if the resi	dent had eaten anything			Not Crush medications have the		
	since administeri				potential to be affected. These residents will have physician	;	
					orders reviewed by nurse		
	Information	omning "NI or all a Tar 11 a "			management personnel Monda	_{av -}	
		cerning "Novolog Insulin"			Friday, excluding holidays, to	~ <i>;</i>	
	was provided by	the facility on 2/25/11 at			identify physician orders for Do	o	

011149

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/25/2011	
	PROVIDER OR SUPPLIER		STREET 7510 R	ADDRESS, CITY, STATE, ZIP CODE COSEGATE DR JAPOLIS, IN46237	1
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	within 5 to 10 m	d "You should eat a meal inutes of receiving d low blood sugar."		Not Crush medications. Physician orders will be obtained for those residents indentified to have insulin requiring administration with the Licensed nurses will be re-educated on following physician orders by the Pharmacist and/or DNS. Where measures will be put into ploor what systemic changes ywill make to ensure that the deficient practice does not recur? Resident's receiving Not Crush Medications will have medication cards and MAR's labeled DO NOT Crush. Pharmacist will conduct medication pass audits on the nurses monthly. Licensed nurses will be educated on he identify medications that are to be crushed and insulin's the require administration with for How the corrective action (swill be monitored to ensure deficient practice will not reie., what quality assurance program will be put into plate. A Physician Order/MAR CQ audit tool will be utilized to reappropriate identification of medications that cannot be crushed and insulin's that must be administered with food we x 4, monthly x2 months and quarterly thereafter. Results the audit will be presented to CQI Committee monthly to ensure compliance and follow Identified noncompliance may	at ace you Do ave ree ow to not eat od. s) the cur, ce? Il view st eekly s of the v-up.

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN46237				
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				result in staff re-education a disciplinary action.	ind/or		

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within specified time. Residents' #1, #3, #16, #36, #87 and#133 were monitored by nursing staff with no signs or symptoms of infection noted. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be glucometer with the cloth. The nurse then took the glucometer in to the resident's room and performed a blood glucose test. The manufacturer's information for the product "Sani-Cloth HB" was provided by the Director of Nursing (DON) on 2/24/11 at 2:50 p.m. Documentation indicated, the contact time of the solution to remain on the glucometer, to kill certain blood home athogons should be 10 minutes		• •						
1. On 2/24/11 at 1:10 p.m., LPN # 23 performed a blood sugar test on resident #116. Prior to performing the test, LPN #23 took a wet cloth from a container titled "Sani-Cloth HB Germicidal Disposable Wipe" and wiped the glucometer with the cloth. The nurse then took the glucometer in to the resident's room and performed a blood glucose test. The manufacturer's information for the product "Sani-Cloth HB" was provided by the Director of Nursing (DON) on 2/24/11 at 2:50 p.m. Documentation indicated, the contact time of the solution to remain on the glucometer, to kill certain blood home pathogens should be 10 minutes		Findings include	•			blood glucose monitor to dry		
performed a blood sugar test on resident #116. Prior to performing the test, LPN #23 took a wet cloth from a container titled "Sani-Cloth HB Germicidal Disposable Wipe" and wiped the glucometer with the cloth. The nurse then took the glucometer in to the resident's room and performed a blood glucose test. The manufacturer's information for the product "Sani-Cloth HB" was provided by the Director of Nursing (DON) on 2/24/11 at 2:50 p.m. Documentation indicated, the contact time of the solution to remain on the glucometer, to kill certain blood borne pathogens should be 10 minutes were monitored by nursing staff with no signs or symptoms of infection noted. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have been identified that are currently receiving blood glucose monitoring. Nursing staff has been in-serviced on the recommended manufacturer guidelines of the use of the Sani-clothes used to clean blood glucose monitors. · All residents receiving perineal and/or Foley catheter care have been identified. Nursing staff has been in-serviced on proper infection		1 mamgs merade	•					
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#116. Prior to performing the test, LPN #23 took a wet cloth from a container titled "Sani-Cloth HB Germicidal Disposable Wipe" and wiped the glucometer with the cloth. The nurse then took the glucometer in to the resident's room and performed a blood glucose test. The manufacturer's information for the product "Sani-Cloth HB" was provided by the Director of Nursing (DON) on 2/24/11 at 2:50 p.m. Documentation indicated, the contact time of the solution to remain on the glucometer, to kill certain blood borne pathogens should be 10 migutes			•				п	
#23 took a wet cloth from a container titled "Sani-Cloth HB Germicidal Disposable Wipe" and wiped the glucometer with the cloth. The nurse then took the glucometer in to the resident's room and performed a blood glucose test. The manufacturer's information for the product "Sani-Cloth HB" was provided by the Director of Nursing (DON) on 2/24/11 at 2:50 p.m. Documentation indicated, the contact time of the solution to remain on the glucometer, to kill certain blood borne pathogens should be 10 minutes.		•	•					
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titled "Sani-Cloth HB Germicidal Disposable Wipe" and wiped the glucometer with the cloth. The nurse then took the glucometer in to the resident's room and performed a blood glucose test. The manufacturer's information for the product "Sani-Cloth HB" was provided by the Director of Nursing (DON) on 2/24/11 at 2:50 p.m. Documentation indicated, the contact time of the solution to remain on the glucometer, to kill certain blood borne pathogens should be 10 minutes the same deficient practice and what corrective action will be taken? All residents have been identified that are currently receiving blood glucose monitoring. Nursing staff has been in-serviced on the recommended manufacturer guidelines of the use of the Sani-clothes used to clean blood glucose monitors. All residents receiving perineal and/or Foley catheter care have been identified. Nursing staff has been in-serviced on proper infection							-	
Disposable Wipe" and wiped the glucometer with the cloth. The nurse then took the glucometer in to the resident's room and performed a blood glucose test. The manufacturer's information for the product "Sani-Cloth HB" was provided by the Director of Nursing (DON) on 2/24/11 at 2:50 p.m. Documentation indicated, the contact time of the solution to remain on the glucometer, to kill certain blood borne pathogens should be 10 minutes. what corrective action will be taken? · All residents have been identified that are currently receiving blood glucose monitoring. Nursing staff has been in-serviced on the recommended manufacturer guidelines of the use of the Sani-clothes used to clean blood glucose monitors. · All residents receiving perineal and/or Foley catheter care have been identified. Nursing staff has been in-serviced on proper infection		titled "Sani-Cloth	n HB Germicidal					
took the glucometer in to the resident's room and performed a blood glucose test. The manufacturer's information for the product "Sani-Cloth HB" was provided by the Director of Nursing (DON) on 2/24/11 at 2:50 p.m. Documentation indicated, the contact time of the solution to remain on the glucometer, to kill certain blood borne pathogens should be 10 minutes.		Disposable Wipe	" and wiped the			· ·		
took the glucometer in to the resident's room and performed a blood glucose test. The manufacturer's information for the product "Sani-Cloth HB" was provided by the Director of Nursing (DON) on 2/24/11 at 2:50 p.m. Documentation indicated, the contact time of the solution to remain on the glucometer, to kill certain blood borne pathogens should be 10 minutes.		glucometer with	the cloth. The nurse then			taken? · All residents have be	en	
room and performed a blood glucose test. The manufacturer's information for the product "Sani-Cloth HB" was provided by the Director of Nursing (DON) on 2/24/11 at 2:50 p.m. Documentation indicated, the contact time of the solution to remain on the glucometer, to kill certain blood borne pathogens should be 10 minutes.		took the glucome	eter in to the resident's			1		
The manufacturer's information for the product "Sani-Cloth HB" was provided by the Director of Nursing (DON) on 2/24/11 at 2:50 p.m. Documentation indicated, the contact time of the solution to remain on the glucometer, to kill certain blood borne pathogens should be 10 minutes.		•						
The manufacturer's information for the product "Sani-Cloth HB" was provided by the Director of Nursing (DON) on 2/24/11 at 2:50 p.m. Documentation indicated, the contact time of the solution to remain on the glucometer, to kill certain blood borne pathogens should be 10 minutes.								
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the Director of Nursing (DON) on 2/24/11 at 2:50 p.m. Documentation indicated, the contact time of the solution to remain on the glucometer, to kill certain blood borne pathogens should be 10 minutes Sani-clothes used to clean blood glucose monitors. · All residents receiving perineal and/or Foley catheter care have been identified. Nursing staff has been in-serviced on proper infection								
at 2:50 p.m. Documentation indicated, the contact time of the solution to remain on the glucometer, to kill certain blood borne pathogens should be 10 minutes.						_	od	
the contact time of the solution to remain on the glucometer, to kill certain blood borne pathogens should be 10 minutes catheter care have been identified. Nursing staff has been in-serviced on proper infection						-		
on the glucometer, to kill certain blood borne pathogens should be 10 minutes identified. Nursing staff has been in-serviced on proper infection		-					y	
borne pathogens should be 10 minutes in-serviced on proper infection								
		on the glucomete	er, to kill certain blood			_		
Control procedures during		borne pathogens	should be 10 minutes.					
						Total procedures during		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER.		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION ID		IDENTIFICATION NUMBER:				COMPLETED	
		155757	B. WING 02/25/2011			02/25/2011	
			D		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				OSEGATE DR		
ROSEGATE VILLAGE LLC					IAPOLIS, IN46237		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	at 1:45 p.m., the been inserviced to solution only had DON went on to have been inserviced glucometer to has solution for 10 mm. 2. On 2/23/11 at provided perical CNAs while weat feces from the retrectal area. While gloves, the CNA privacy curtain, it bag from her poor	tye contact with the ninutes. 1 p.m., CNAs #8 re for resident #133. The uring gloves, cleansed sident's buttocks and le wearing the same is touched the resident's removed a clear plastic eket, open the bag to ins and touched the			perineal and Foley catheter cate What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? Blood glucose monitors are to be disinfected with a new Supe Sani-Cloth with a contact time minutes or less. Nursing sto will be educated on the proper procedures identified in the manufacturer's guidelines for a did nursing staff for proper perineal and Foley catheter cate All staff has been educated of infection control and hand washing procedure by DNS/designee. How the corrective action (s) will be monitored to ensure the deficient practice will not receive, what quality assurance program will be put into plac A CQI monitoring tool will be utilized by DNS/designee to observe blood glucose monito cleaning weekly X 4 weeks, monthly X 2 months and quart thereafter. A CQI monitoring will be utilized by nurse management team to observe nursing staff perform resident care including perineal and Fo catheter care. Resident care observations will be conducted weekly X 4 weeks, monthly X months and quarterly thereafter. Infection Control results will to	o er of aff	

011149

AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING	I 02/25/2011				
NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN46237					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	presented to the CQI commit monthly to review for complia and follow-up. Identified noncompliance may result in re-education and/or disciplina action.	tee ince staff			

F0441 SS=E Tag	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 155757			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/25/2011	
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F0441 SS=E 3. During initial tour with RN #1 on 2/21/11 at 11:05 a.m., Resident #36 was identified as utilizing an indwelling Foley catheter and leg bag with an as needed continuous bladder irrigation. F042/1/11 at 12:00 p.m., RN #16 was observed to disconnect PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX TAG (EACH CORRECTIVE action should be cross-Referenced to the APPROPRIATE DEFICIENCY. PREFIX TAG (EACH CORRECTIVE action should be cross-Referenced to the APPROPRIATE DEFICIENCY. PREFIX TAG (EACH CORRECTIVE action should be cross-Referenced to the APPROPRIATE DEFICIENCY. PREFIX TAG (EACH CORRECTIVE action should be cross-Referenced to the APPROPRIATE DEFICIENCY. TAG (SACH CORRECTIVE action should be completed to the APPROPRIATE DEFICIENCY. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • The blood glucose monitor for resident #116 was disinfected per manufacturer's guidelines. • Licensed nurses have been educated on the proper procedures for the use of the Sani-Cloth HB in regards to the contact time information noted in the manufacturer's guidelines. • Additional blood glucose monitors were made available on licensed nurses'	ROSEGATE VILLAGE LLC			7510 ROSEGATE DR				
be accomplished for those residents found to have been affected by the deficient practice? The blood glucose monitor for resident #116 was disinfected per manufacturer's guidelines. Licensed nurses have been educated on the proper procedures for the use of the Sani-Cloth HB in regards to the contact time information noted in the manufacturer's guidelines. Additional blood glucose monitors were made available on licensed nurses'	PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤΕ	COMPLETION DATE
Resident #36's leg bag from the Foley catheter, attach a regular urinary drainage bag, and attach a continuous bladder irrigation tubing to the Foley catheter. RN #16 put on a clean pair of gloves, moved the bladder irrigation pole from one side of the bed to the other. With the same gloves on RN #16 disconnected the leg bag, swabbed the catheter with an alcohol pad, attached a new drainage bag, cleansed the end of the flush tubing with an medication cards to allow one blood glucose monitor to dry within specified time. Residents' #11, #3, #16, #36, #87 and#133 were monitored by nursing staff with no signs or symptoms of infection noted. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have been identified that are currently receiving blood glucose monitoring. Nursing staff has been in-serviced on the recommended manufacturer guidelines of the use of the Sani-clothes used to clean blood glucose monitors. All residents receiving perineal and/or Foley catheter care have been identified. Nursing staff has been in-serviced on proper infection control procedures during		#1 on 2/21/1 Resident #30 utilizing and catheter and needed continiringation. On 2/25/11 at #16 was obstrained a continiringation tulicatheter. RN clean pair of bladder irrigation tulicatheter. RN clean pair of bladder irrigation to bladder	at 11:05 a.m., 6 was identified as indwelling Foley leg bag with an as inuous bladder at 12:00 p.m., RN terved to disconnect 6's leg bag from the er, attach a regular mage bag, and tinuous bladder bing to the Foley N #16 put on a f gloves, moved the gation pole from the bed to the other. The gloves on RN tected the leg bag, attached a new g, cleansed the end	F04	41	be accomplished for those residents found to have been affected by the deficient practice? The blood glucose monitor for resident #116 was disinfected per manufacturer's guidelines. Licensed nurses have been educated on the proper procedures for the use the Sani-Cloth HB in regards to the contact time information noted in the manufacturer's guidelines. Additional blood glucose monitors were made available on licensed nurses' medication carts to allow one blood glucose monitor to dry within specified time. Reside #1, #3, #16, #36, #87 and #133 were monitored by nursing stawith no signs or symptoms of infection noted. How will yo identify other residents having the potential to be affected by the same deficient practice as what corrective action will be taken? All residents have be identified that are currently receiving blood glucose monitoring. Nursing staff has been in-serviced on the recommended manufacturer guidelines of the use of the Sani-clothes used to clean blooglucose monitors. All resident receiving perineal and/or Fole catheter care have been identified. Nursing staff has been in-serviced on proper infection in serviced on proper infection in serviced on proper infection.	of oo of oo onts' 3 uff ung y und e en ood ots y een	03/27/2011

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Event ID:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED B. WING 02/25/2011			
NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				7510 R	ADDRESS, CITY, STATE, ZIP CODE COSEGATE DR JAPOLIS, IN46237 PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	alcohol pad	cy must be perceded by full lsc identifying information) with same gloves		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) perineal and Foley catheter ca What measures will be put in	DATE are.
	opened the rirrigation tubhand. 4. On 2/24/2 CNAs #17 a observed to #87 from the with a mechanism glove handled the tubing and was gloves on respectively.	transfer Resident wheelchair to bed anical lift. While wes, the staff Foley catheter with the same moved the lift sling he resident, and lift before			place or what systemic changes you will make to ensure that the deficient practice does not recur? Blood glucose monitors are to be disinfected with a new Sup Sani-Cloth with a contact time 3 minutes or less. Nursing stoward will be educated on the proper procedures identified in the manufacturer's guidelines for of the new Sani-Cloth. Skills validations will be completed for all nursing staff for proper perineal and Foley catheter care. All staff has been educated of infection control and hand washing procedure by DNS/designee. How the corrective action (s) will be monitored to ensure the deficient practice will not receive, what quality assurance program will be put into place. A CQI monitoring tool will be utilized by DNS/designee to observe blood glucose monitor cleaning weekly X 4 weeks, monthly X 2 months and quart thereafter. A CQI monitoring will be utilized by nurse management team to observe nursing staff perform resident care including perineal and For catheter care. Resident care observations will be conducted weekly X 4 weeks, monthly X months and quarterly thereafter. Infection Control results will be infection Control results will be infection Control results will be infection Control results will infecti	corer of cafff or use for care. on care.

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757		A. BUILDING	COMPLETED 02/25/2011					
		100707	B. WING		02/23/2011			
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE				
ROSEGA	ATE VILLAGE LLC		7510 ROSEGATE DR INDIANAPOLIS, IN46237					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	· · · · · · · · · · · · · · · · · · ·	CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	 				
TAG	· · · · · · · · · · · · · · · · · · ·	LSC IDENTIFYING INFORMATION)	TAG	presented to the CQI commit monthly to review for complia and follow-up. Identified noncompliance may result in re-education and/or disciplina action.	tee ance staff			

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155757	B. WIN			02/25/2011	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				OSEGATE DR		
ROSEGA	TE VILLAGE LLC				IAPOLIS, IN46237		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID (E		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG			+	TAG			DATE
F0441		3:20 p.m., Resident # 3	F04	41	What corrective action(s) will	l	03/27/2011
SS=E	was observed to	receive foley catheter			be accomplished for those		
	care by CNAs #6	and #7. CNAs # 7, with			residents found to have been	1	
	gloves on, was o	bserved to remove the			affected by the deficient practice? The blood glucose		
	_	brief. Without changing			monitor for resident #116 was		
		l gloves, CNAs #7			disinfected per manufacturer's		
		dent's pillow. The CNAs			guidelines. · Licensed nurses		
		•			have been educated on the		
	_	gloves and provided			proper procedures for the use		
	foley catheter care for Resident #3. Without changing the contaminated gloves, the CNAs adjusted the resident's gown and bed linens.				the Sani-Cloth HB in regards to	0	
					the contact time information		
					noted in the manufacturer's guidelines. · Additional blood		
					glucose monitors were made		
					available on licensed nurses'		
	6. On 2/24/11 at	11:30 a.m., CNAs #13			medication carts to allow one		
		toilet Resident #16. The			blood glucose monitor to dry		
		res on, removed the			within specified time. · Reside		
	resident's brief so				#1, #3, #16, #36, #87 and#133		
					were monitored by nursing sta with no signs or symptoms of	π	
		resident was observed to			infection noted. How will you	.	
		ovement while on the			identify other residents havir		
		e. The CNAs with the			the potential to be affected by	- 1	
	same gloves on v	viped the resident with			the same deficient practice a	- 1	
	toilet paper. With	nout changing the			what corrective action will be		
	contaminated glo	oves, the CNAs turned off			taken? · All residents have be	en	
		n sounding, pulled up the			identified that are currently		
	-	transferred the resident,			receiving blood glucose		
	•	belt around the resident,			monitoring. Nursing staff has		
	_	·			been in-serviced on the recommended manufacturer		
and put the wheelchair legs back or		_			guidelines of the use of the		
	resident's wheelchair.				Sani-clothes used to clean blo	od	
					glucose monitors. · All residen		
		12 p.m., CNAs #11 and			receiving perineal and/or Foley		
	#12 were observe	ed to transfer Resident #1			catheter care have been		
	and provide inco	ntinence care to the			identified. Nursing staff has be		
		NAs were observed to			in-serviced on proper infection		
					control procedures during		
					<u> </u>		

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EQ7B11 Facility ID: 011149

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			survey eted 011
	PROVIDER OR SUPPLIEF	!! !	STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN46237				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	and tubing without washing their had transferring Resilift, CNAs #11, wobserved to again foley catheter bachanging the corn CNAs opened the removed the was moved the resided Review of the faprocedures [no a.m. indicated "washed:b. Before care procedures, and other protect touching the next touching a resided resided resided touching a resided transfer of the care procedures.	dent #1 with the hoyer with gloves on, was n handle the resident's g and tubing. Without ntaminated gloves, the e resident's closet, sh basin from closet, and			perineal and Foley catheter combinations will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? Blood glucose monitors are be disinfected with a new Sup Sani-Cloth with a contact time 3 minutes or less. Nursing swill be educated on the prope procedures identified in the manufacturer's guidelines for of the new Sani-Cloth. Skills validations will be completed all nursing staff for proper perineal and Foley catheter combined and washing procedure by DNS/designee. How the corrective action (s) will be monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place. A CQI monitoring tool will be utilized by DNS/designee to observe blood glucose monitor cleaning weekly X 4 weeks, monthly X 2 months and quart thereafter. A CQI monitoring will be utilized by nurse management team to observe nursing staff perform resident care including perineal and For catheter care. Resident care observations will be conducted weekly X 4 weeks, monthly X months and quarterly thereafter. Infection Control results will	to per e of taff r use for are. on terly tool e obley d 2 er.	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757			A. BUILDING B. WING	UNSTRUCTION	COMPL 02/25/2	ETED		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR					
ROSEGA	TE VILLAGE LLC		INDIANAPOLIS, IN46237					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
I			1	presented to the CQI commit monthly to review for complia and follow-up. Identified noncompliance may result in re-education and/or disciplina action.	tee ince staff			